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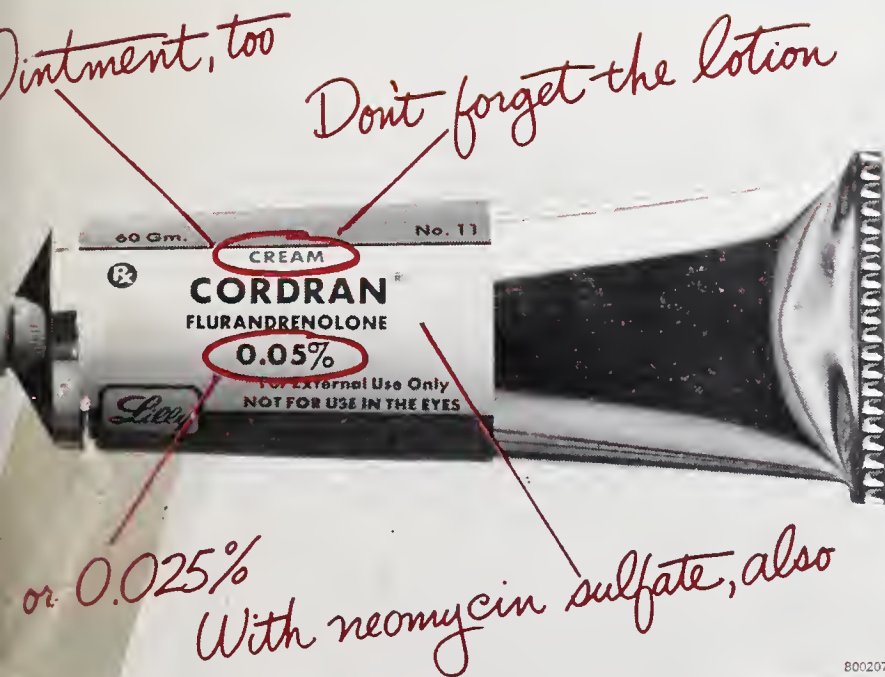
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HAWAII MEDICAL JOURNAL



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Tests for Syphilis

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VOLUME 28 • NUMBER 1

247233

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EXPECTORANT

Each fluidounce contains: 80 mg.

Benadryl[®] (diphenhydramine hydrochloride, Parke-Davis);

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Correspondence

Pesticide Poisoning

TO THE EDITOR:

Pesticide poisonings are likely to become a matter of increasing concern to physicians in this State.

Of all the types of pesticide used in Hawaii, specific therapy is available for poisoning with only one group—the organophosphates. In severe cases diagnosis must be prompt and therapy immediate to be effective. The onset of severe symptoms has been known to occur in less than five minutes of a dose entering by the respiratory tract.

I should like to suggest that the following routine be adopted for patients presenting with nausea, vomiting and vertigo in whom organophosphates are KNOWN TO BE THE NOXIOUS AGENT:

1. If the patient is cyanosed, aspirate excess secretions from the bronchial tree. Respire artificially if necessary.

2. Withdraw 15 ml blood for cholinesterase determinations and pesticide analysis (7 ml in heparinised tube, 8 ml in plain tube). Through same needle inject first dose of atropine sulphate. For moderately severe poisoning 2 mgm. For severe poisoning 4 mgm.

3. Repeat dose of atropine every 3-10 minutes until patient is fully atropinised in severe cases, every hour in less severe cases.

4. For severe poisoning, and always if muscle twitching or weakness are present:

Administer pralidoxime iodide (2-PAM, Protopam), 1 gramme slowly intravenously (0.25 gm for infants). For very severe cases 2 gm may be given. The 1 gm dose may be repeated if there is not marked improvement within one hour.

5. Decontaminate skin, hair, eyes, GI tract as indicated by known route of exposure.

6. A mild degree of atropinisation will be required for at least 24 hours in mild cases, and 48 hours in severe cases. Pralidoxime may be repeated at 8-12 hours, but is unlikely to be effective if the first dose has produced no effect.

NOTE: Respiratory depressants and barbiturates are always contraindicated in these cases. Authority for this alarmingly high dosage of atropine can be found in Goodman & Gilman's "Pharmacological Basis of Therapeutics," and in Hayes' "Clinical Handbook of Economic Poisons," U.S. Public Health Service Publication No. 476, as well as in the accounts of the successful management of such cases in the literature.

Where there is doubt whether organophosphate or organochlorine and especially pentachlorophenol is the pesticide group involved (an almost impossible differentiation on clinical grounds) it is wise to await the result of the cholinesterase determination, since the management is different. Atropine sulphate is absolutely contraindicated in pentachlorophenol poisoning.

The value of pralidoxime is proven in parathion poisoning, but variable and less certain with the other organophosphates. The condition for which it is given is sufficiently grave to justify its trial in organophosphate poisonings other than parathion. It should be given early in management because it is designed to detach phosphate blocking enzyme receptor sites, and the enzyme-phosphate complex undergoes further change in time, increasing its stability.

The Pesticide Project, University of Hawaii (Tel. 944-8881) is glad to be involved in case investigation, and its laboratory staff will kindly give their off-duty time when emergency cholinesterase determinations are necessary. Specimens requested are 15 ml blood (as under 2 above) and 25 ml urine.

GLADYS C. FRYER, M.D.
Clinician
University of Hawaii

July 31

Gown vs. Town?

TO THE EDITOR:

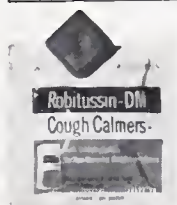
Please accept my compliments on your excellent editorial in the May-June issue of the HAWAII MEDICAL JOURNAL, entitled "Relax, Professor: We'll Bear the Burden."

I think that your points are extremely well made and are very timely. Having recently been in Seattle during the formation of the medical school there, I find that we here in Hawaii are having exactly the same problems that presented themselves during the formation of that university.

Your final paragraph is certainly an excellent one. We all would like to help and we are willing to be helped but certainly as you so aptly put it we're not interested in being supplanted.

GEORGE BRACHER, M.D.
Hilo Hospital

August 2



Each Cough Calmer™ contains the same active ingredients as a half-teaspoonful of Robitussin-DM®: Glyceryl guaiacolate, 50 mg; Dextromethorphan hydrobromide, 7.5 mg. A H Robins Company, Richmond, Virginia 23220

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A specific solution for tinea versicolor

Although tinea versicolor is not a serious disease it is chronic and recurrent and specific treatment is cosmetically important. "Of the wide variety of compounds recommended for the treatment of tinea versicolor, sodium thiosulphate still remains the standard."^{*} However, when sodium thiosulfate is administered alone it decomposes rapidly and produces an offensive odor. These disadvantages have been largely eliminated by the development of TINVER Lotion, which contains sodium thiosulfate and salicylic acid in MICEL A[®] base.[†]

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practical and economical for long-term therapy.

Indications: For topical use in the treatment of tinea versicolor.

Precautions: If signs of irritation or sensitivity develop, discontinue use. Do not use on or about the eyes.

Dosage and Administration: Thoroughly wash, rinse, and dry the affected area before applying medication. Apply a thin film of the lotion twice a day, or as directed. Although diagnostic evidence of the tinea versicolor may disappear in a few days, it is advisable to

continue treatment for a much longer period. Clothing should be boiled to prevent reinfection.

Supply: 5 oz. polyethylene squeeze bottle.

^{*}McClarín, W. M., and Knox, J. M.: *Cutis* 3:619 (June) 1967.

[†]The MICEL A[®] base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.



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Sodium thiosulfate USP 25%, salicylic acid USP 1%, isopropyl alcohol NF 10%, and propylene glycol USP, in a MICEL A base of menthol USP, disodium edetate, colloidal alumina, and purified water USP.



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Describes those services not shown elsewhere, like DATA-PAC's newly-instituted School Scheduling program. Many other local and mainland firms have tried to solve the problem of "getting the right student in the right class" in Hawaii but, thus far, only DATA-PAC has succeeded.

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DATA-PAC processes reports of service performed on all equipment used by the Army in Viet Nam. This service for the Army Equipment Records System (TAERS) involves approximately 1,000,000 entries per month.

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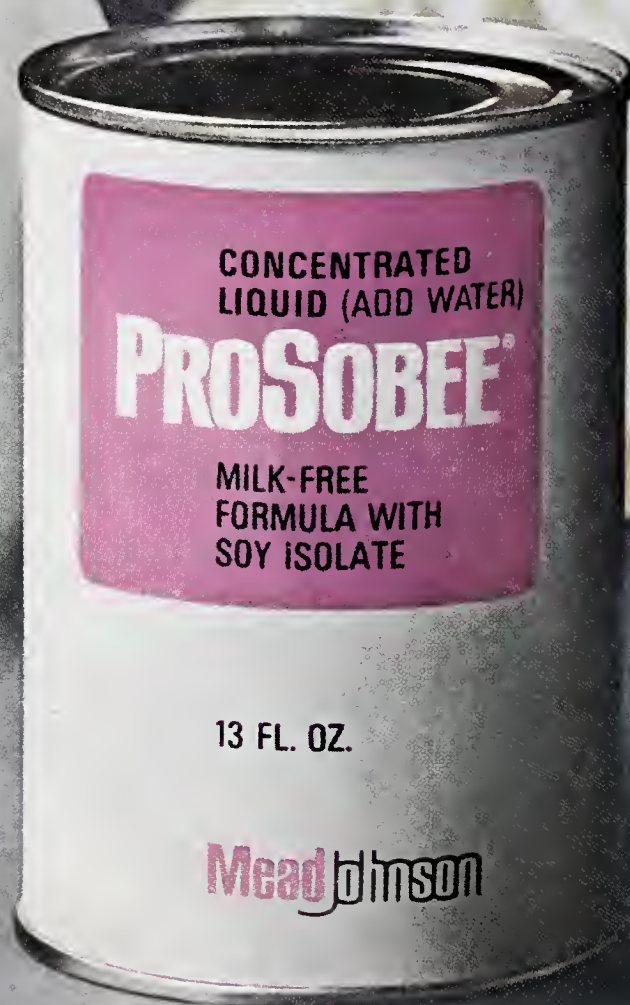
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1. Harkins, R. W., and Sarett, H. P.: J. Nutrition 91:213-218 (Feb.) 1967.

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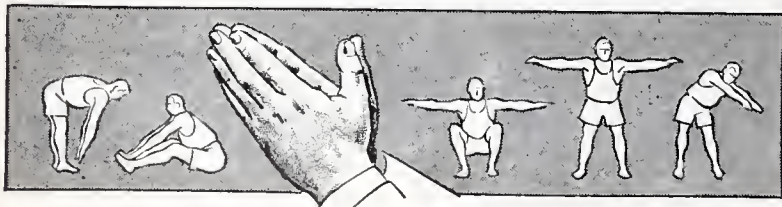


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OF WATERLOO BECAUSE
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ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK "PRAY YOUR WEIGHT AWAY" URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.

GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS. 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.



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*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOSI

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

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(Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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New

Tegretol[®] carbamazepine

Therapeutic breakthrough in non-narcotic control of the pain of trigeminal neuralgia

Warning

Fatal cases of aplastic anemia have been reported following treatment with Tegretol. Agranulocytosis, thrombocytopenia and transitory leukopenia have also been observed.

Complete blood and platelet counts should be done prior to and at regular intervals during treatment with the drug (see recommendations under "Important Note and Precautions") to help in the early detection of serious bone marrow injury. Abnormalities in initial blood tests should rule out use of the drug. Also, patients should be made aware of such early toxic signs of a potential hematologic problem as fever, sore throat, mouth ulcers, easy bruising and petechial or purpuric hemorrhage. Should such signs appear, the patient should be advised to discontinue the drug and to report to the physician immediately.

Indication Tegretol is indicated in the treatment of the pain associated with true trigeminal neuralgia. It is not a simple analgesic and should never be administered for relief of trivial facial aches or pains.

Contraindication Do not use in those with a known sensitivity to any tricyclic compound or in those being treated with M.A.O.I. agents. As long a period as possible should elapse before using Tegretol in patients who have been treated with M.A.O.I.'s, with a minimum of 7 days. In such cases, initial dosage should be low and the patient's reaction to gradual increments closely observed.

Important Note and Precautions Familiarity with the clinical symptoms which lead to an accurate diagnosis of true trigeminal neuralgia and with the complete prescribing information, careful patient selection, a thorough examination before treatment and close patient supervision throughout the treatment period are essential to the safe and effective use of this drug.

Where feasible, Tegretol should not be used in conjunction with any potent drug which may increase the possibility of toxic reactions.

In pregnancy, the drug should not be prescribed during the first trimester and thereafter only to patients in whom the clinical situation warrants the potential risk. It should not be administered to nursing mothers.

Patients with increased intraocular pressure should be closely observed during treatment with this drug because of its anticholinergic effect.

Because of the drug's relationship to other tricyclic compounds, the possibility of activation of latent psychosis and, in the elderly, of confusion or agitation, should be considered.

Dizziness and drowsiness may occur and patients should be cautioned about the hazards of operating machinery or automobiles and of engaging in other hazardous tasks.

Use cautiously in patients with a history of coronary artery disease, organic heart disease, congestive failure or liver disease.

Before initiating therapy, the following laboratory procedures should be performed:

1. Complete blood and platelet counts which, if abnormal, should rule out the use of the drug.

2. Baseline evaluations of liver function.

During treatment with Tegretol, the following laboratory procedures should be performed:

1. Complete blood and platelet counts should be done at intervals of one week during the first month of drug treatment, every two weeks during the second and third months, and at monthly intervals thereafter for as long as the patient is taking the drug. A trend toward a decreasing white blood cell count should suggest a dosage reduction and more frequent

laboratory and clinical evaluations. Should this trend continue, the drug should be discontinued.

2. Liver function tests must be performed at regular intervals during treatment with this drug since liver damage may occur during therapy. The drug should be discontinued immediately in cases of aggravated liver dysfunction or active liver disease.

3. Periodic eye examinations, including slit-lamp, funduscopy and tonometry, are recommended for patients being treated with this drug since many phenothiazines and related drugs have been shown to cause eye changes.

4. Complete urinalysis and BUN should be done on patients treated with Tegretol because of observed renal dysfunction.

Adverse Reactions Dizziness, drowsiness, unsteadiness on the feet, nausea, vomiting, aplastic anemia, transitory leukopenia, agranulocytosis, eosinophilia, leukocytosis, thrombocytopenia, purpura, abnormalities in liver function tests, cholestatic and hepatocellular jaundice, urinary frequency, acute urinary retention, oliguria with elevated blood pressure, albuminuria, glycosuria, elevated BUN, microscopic deposits in the urine, impotence, disturbances of coordination, confusion, headache, fatigue, blurred vision, transient diplopia and oculomotor disturbances, speech disturbances, abnormal involuntary movements, peripheral neuritis and paresthesias, depression with agitation, talkativeness, nystagmus, tinnitus, paralysis and other symptoms of cerebral arterial insufficiency, pruritic and erythematous rashes, urticaria, Stevens-Johnson syndrome, photosensitivity reactions, alterations in skin pigmentation, exfoliative dermatitis, alopecia, diaphoresis, recurrence of thrombophlebitis, erythema multiforme and nodosum, aggravation of disseminated lupus erythematosus, gastric distress, abdominal pain, diarrhea, constipation, anorexia, dryness of the mouth and pharynx, glossitis, stomatitis, fever, chills, adenopathy, lymphadenopathy, aching joints and muscles, leg cramps, conjunctivitis, left ventricular failure, aggravation of hypertension, hypotension, syncope and collapse, edema, aggravation of coronary artery disease and congestive heart failure. (Whether these cardiovascular effects are drug-related is not known. However, some of these complications have resulted in fatalities.) The necessity for discontinuing the drug should be dictated by the gravity and severity of the adverse reactions.

Dosage and Administration The drug should always be taken with meals, if possible.

Initial: One-half tablet (100 mg.) b.i.d. on the first day. Thereafter, the dose should be increased in one-half tablet (100 mg.) increments every 12 hours until freedom from pain is achieved. To relieve pain, between 200 mg. and 1200 mg. per 24 hours may be necessary.

Maintenance: Initial control of pain can be maintained in most patients with a dose of 400 mg. to 800 mg. daily. Maintenance doses may range between 200 mg. and 1200 mg. daily.

At least once every 3 months during treatment period attempts should be made to discontinue the drug or to reduce the dose to the minimum effective level.

Availability Round, white, single-scored tablets of 200 mg. in bottles of 100 and 1000. (B)46-820-A

For complete details, please see Prescribing Information.

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And let you control the dosage.

With Novahistine LP tablets and Novahistine Singlet[™] tablets you have the range and flexibility of decongestant dosage that lets you prescribe for the needs of the individual patient.

Novahistine LP tablets are most useful for relief of nasal congestion in patients without pain or fever.

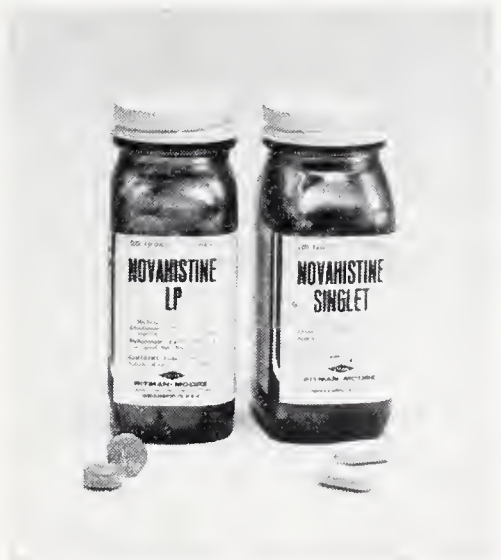
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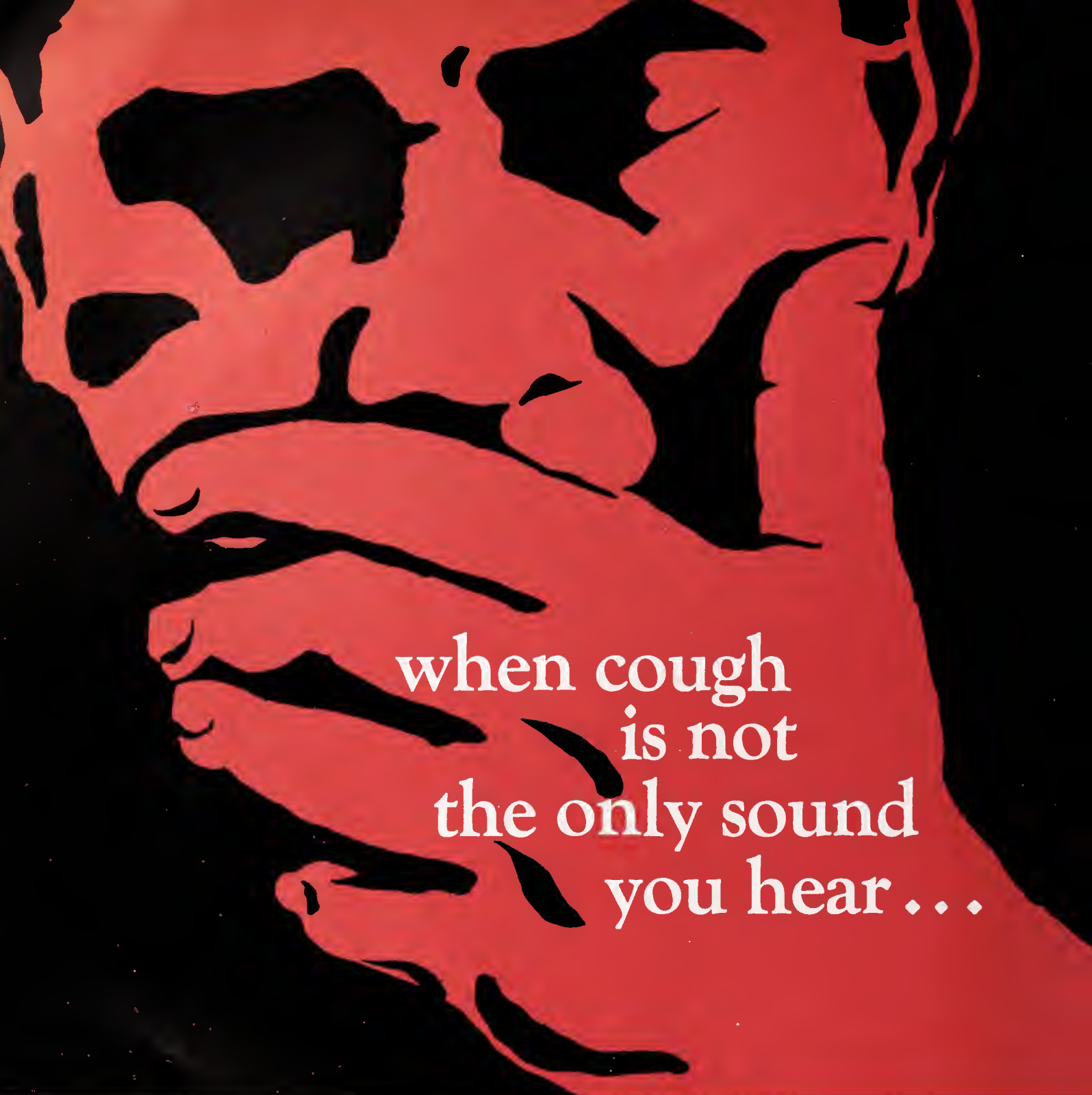
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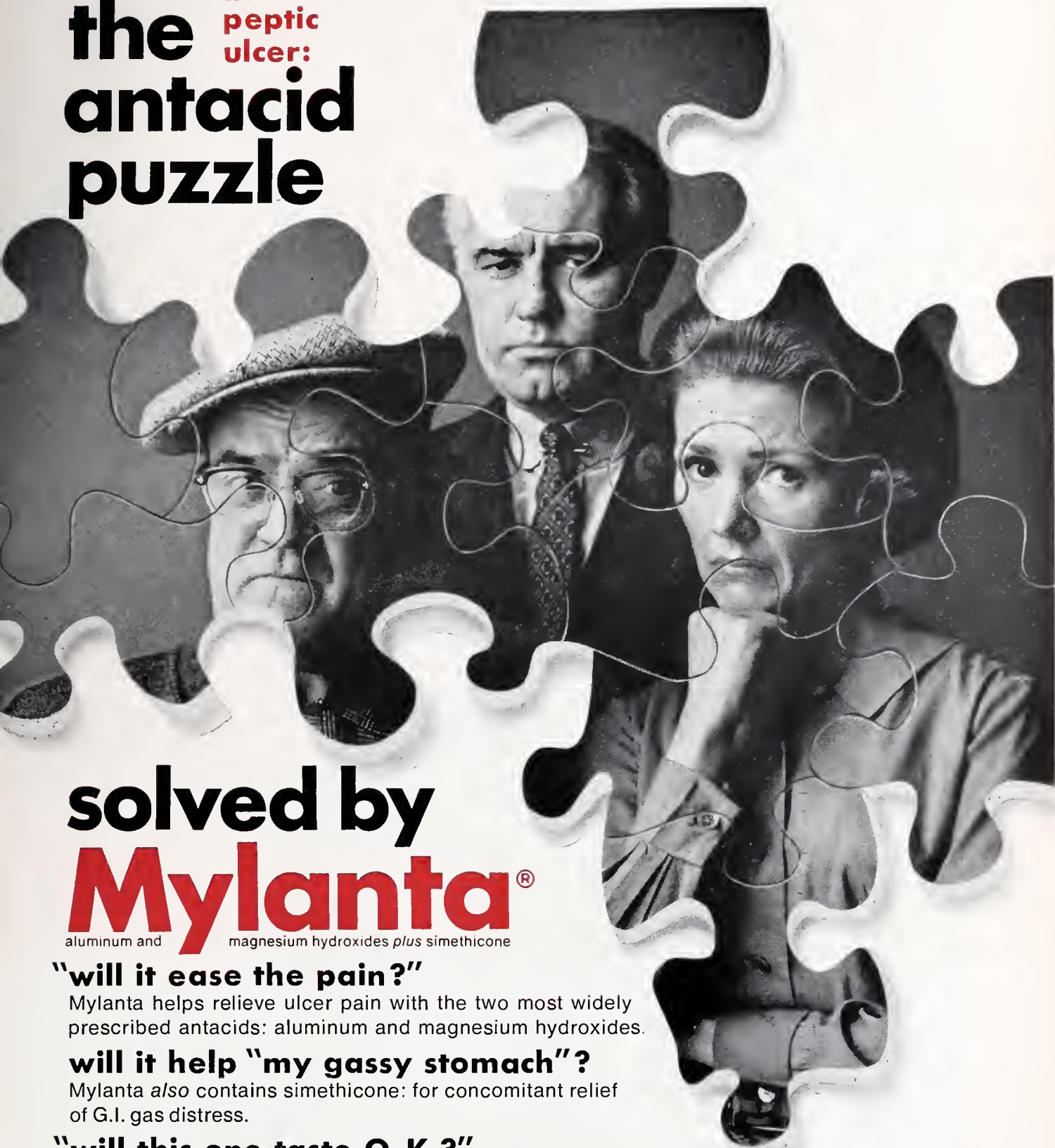
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*Ciguatera poisoning in French Polynesia is rarely fatal
even though the treatment must be mainly symptomatic.*

Clinical Aspects of Ciguatera (Fish Poisoning) in French Polynesia

RAYMOND BAGNIS, M.D.,* Papeete, Tahiti

● Among 350 ciguatera poisoning cases seen by the author, only three died, none of them clearly from this alone. Symptoms tended to fall into one of four categories: digestive, cardiovascular, neurologic, or general. Gastrointestinal and neurologic symptoms are more common in cases caused by eating herbivorous surgeonfishes; cardiovascular disorders and more varied symptoms are common when piscivorous groupers or snappers have caused the poisoning. Treatment with injected protopam chloride, atropine, and vitamins appears to be helpful.

POISONING FOLLOWING the consumption of fresh fish has long been known in islands of the South Pacific. Early navigators, such as Fernandez de Queiros in 1606, Cook and Forster in 1776, and Jules Garnier in 1875 recorded experiences with such poisoning in their log books.

The name of ciguatera, of Cuban origin, was first given to an illness caused by eating certain fishes in the West Indies. The symptoms of tropical Atlantic and South Pacific cases of fish poisoning have not been differentiated, and this term is

now broadly applied to the disorder throughout tropic seas. Ciguatera is clearly distinct from tetraodont (puffer) poisoning or histaminic fish poisoning.

Banner (1966),¹ however, has pointed out that more than one toxin is responsible for producing the illness that we call ciguatera. It is possible that the variation in symptomatology that we have observed among ciguatera patients in French Polynesia is the result of two or more toxins' being present in varying amounts in the poisonous fishes that were eaten.

The islands of French Polynesia are prominent among the insular regions of the Pacific from which ciguatera has been reported. Belotte (1955)² attempted the first inventory of toxic fishes of Tahiti and presented a detailed history of a near-fatal case of poisoning from the snapper *Lutjanus monostigmus*. In his general review of ciguatera, Randall (1958)³ identified a number of toxic fishes from the Society Islands, and Randall and Broek (1960)⁴ presented food-habit data for some of these fishes.

For two years beginning January 1, 1964, as an itinerant doctor in the Tuamotu and Gambier archipelagoes, I had the opportunity to observe more than 200 patients suffering from ciguatera. Additional cases, primarily from Tahiti, have increased the total number of patients examined to

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350. A summary of the observations on these patients is the principal purpose of this paper. Most of the clinical data were obtained by me, but some were provided by other physicians of the Territorial Health Service.

I wish to acknowledge the help of my colleagues, principally Dr. Alain Rougier and Dr. Albert Voinesson in the Western Society Islands, Dr. Michel Casteran in the Marquesas Islands, Dr. Jacques Etchepare in the Austral Islands, and Mr. Jack Bennet of the Institut de Recherches Médicales de la Polynésie Française. Also I am grateful to Dr. Michael M. Okihira of the Straub Clinic in Honolulu; to Dr. Martin D. Rayner of the Department of Physiology, School of Medicine, University of Hawaii; and to Dr. John E. Randall of the Hawaii Institute of Marine Biology, University of Hawaii and the Bishop Museum, for review of the manuscript.

EPIDEMIOLOGY

A great many species of reef fishes are capable of causing ciguatera. These belong primarily to the families of moray eels (Muraenidae), mullets (Mugilidae), groupers (Serranidae), snappers (Lutjanidae), porgies (Sparidae and Lethrinidae), jacks (Carangidae), wrasses (Labridae), parrotfishes (Scaridae), surgeonfishes (Acanthuridae), and triggerfishes (Balistidae).

A few species are known to produce symptoms with such frequency and degree of severity as to set them apart from the others. Eight of these are banned from sale in the fish market in Papeete, Tahiti. They are the *ono* (*Sphyræna barracuda*), the *tonu* (*Plectropomus leopardus*), the *hapuu* (a large grouper of the genus *Epinephelus*), the *tai-vaiva* (*Lutjanus monostigmus*), the *haputu* (*Lutjanus rivulatus*), the *haamea* (*Lutjanus bohar*), the *mara* (*Cheilinus undulatus*), and the *oiri* (*Pseudobalistes flavomarginatus*). A recent fatality following a meal of the *maito*, a common surgeonfish (*Ctenochaetus striatus*), resulted in the exclusion of this species from sale also. This death did not present a typical clinical picture and there may have been complications. Although the *maito* is often implicated in ciguatera, the cases are usually not serious.

The incidence of ciguatera within French Polynesia is much greater in the Society Islands, Tuamotu Archipelago, and Marquesas Islands than in the Gambier or Austral groups to the south.

The importance of ciguatera in the islands of higher incidence cannot be underestimated. For some Tuamotu atolls it is the main cause of morbidity. Recent statistics published by the Institut de Recherches Médicales (Malarde, *et al*, 1967)⁵ reveal for the year 1966 a rate of 800 cases per

10,000 inhabitants in Tahiti. Seventy-four were so sick they were hospitalized.

As has been noted by other authors, there is often temporal variation in the occurrence of toxic fishes at any one island. For example, few cases of ciguatera have been reported from Raiatea in recent years, in contrast to the past. In the Tuamotu, on the other hand, some atolls (such as Hikueru) have suddenly had outbreaks following long periods during which ciguatera was practically unknown.

It is also well known that poisonous fishes are often found only on certain reefs or sectors of reefs. The same species of fishes are edible elsewhere around the same island. In Bora Bora, for example, toxic fishes are practically confined to the southern side of the single pass to the lagoon.

CLINICAL STUDIES

The incubation period of ciguatera is variable, depending on the individual and the amount of fish eaten. Usually it varies from two to twenty hours, but in severe cases the latency may be shortened to a few minutes.

The disease presents a polymorphous clinical picture. However, some typical features, coupled with the knowledge that reef fish has been eaten, usually permit a definite diagnosis.

The first symptoms to appear are prickling paresthesia and numbness around the lips, tongue, and nose, and tingling at the ends of the limbs. Concurrently there is discomfort with facial congestion, cold sweating, and nausea.

The major symptoms may be divided into four main categories: digestive, cardiovascular, neurological, and general. The most common symptoms will be discussed under these headings below.

Digestive:

Nausea, often followed by vomiting

Watery stools

Abdominal cramps

Painful defecation

These symptoms generally abate within 24 hours, leaving an asthenic and dehydrated patient.

Cardiovascular:

Pulse slow (35 to 50 beats per minute) and often irregular

Arterial pressure low

Heart sounds distant

Electrocardiograms may show dysrhythmias ranging from sinus bradycardia to bursts of supraventricular or ventricular extrasystoles. Also, there may be first degree A-V block. Only a total of 22 EKG's were taken, however. We intend to continue such investigations.

Cardiovascular disorders usually disappear within 48 to 72 hours.

Neurologic:

Dysesthesia, principally with respect to sensitivity to cold; painful tingling of the palms of the hands and soles of the feet on contact with cold water

Superficial hyperesthesia, with sensation of burning and electric discharge
Often mydriasis is present
Patellar and Achilles reflexes sometimes diminished
Neurologic symptoms generally persist at least one week. It is not unusual to see contact dysesthesia lasting a month.

General:

Asthenia, making it difficult to walk, and sometimes keeping a patient in bed for several days
Arthralgia, especially of the knees, ankles, shoulders, and elbows
Dorsolumbar stiffness
Myalgia, especially the muscles of the legs
Headache
Marked and constant chilliness, but no problems of thermal regulation
Lipothymia and dizziness
Itching sometimes appeared two or three days after ingestion of toxic fish and may persist for many days
Oliguria sometimes occurred during the first 48 hours

We routinely carry out the following laboratory tests of ciguatera patients: blood count, CO₂ combining power, serum protein electrophoresis, colorimetric determination of serum cholinesterase, and the level of chloride, sodium, and potassium in the blood. Thus far none of these tests has shown any characteristic or constant variation from the normal.

Ciguatera in French Polynesia is rarely fatal. Within the last few years only three deaths have been attributed to it, and for none of these can it be said that fish poisoning was the sole cause of death.

SYMPTOMS

Different individuals display great variation in the manifestation of the symptoms of ciguatera. Rarely will two individuals exhibit the same set of symptoms to the same degree, even when they have eaten like amounts of the same toxic fish. It has been possible to classify individuals, however, into groups according to the principal symptoms. These are as follows:

Neurologic symptoms predominating (112 cases):

Paresthesia and dysesthesia, coupled with arthralgia, myalgia and chilliness, prevail to such a degree that digestive and other symptoms seem minor by contrast.

Digestive features predominating (58 cases):

Vomiting and diarrhea last for three or four days, resulting in intense thirst, dry tongue and skin, and oliguria.

Itching predominating (29 cases):

Strong itching begins on about the third day, first on the extremities, and later general. It is persistent, with nightly exacerbations. It may cause insomnia, and lesions may result from scratching.

Erythema predominating (14 cases):

About 12 hours after ingesting toxic fish an exanthem may occur, with redness and puffiness of the face, urticarial on the limbs near the joints, and diffuse infiltration of the skin. Recovery occurs in four

or five days after a desquamation stage. Children exhibit this form of ciguatera oftener than adults.

Cardiovascular symptoms predominating (7 cases):

The salient symptoms of this form are bradycardia (less than 40 beats per minute), hypotension with a tendency to collapse, and electrocardiographic changes.

Neuromuscular symptoms predominating (7 cases):

Weakness of the legs takes precedence over other symptoms, making it impossible to walk. Often dysphonia is associated with it.

Sensory disturbances predominating (4 cases):

In addition to impairment of motor coordination, we observed significant symptoms of dizziness, visual or auditory diurnal hallucinations, and nightmares with zoopsia.

I have observed that in ciguatera cases resulting from the ingestion of surgeonfishes, which are primarily plant feeders, digestive and neurologic symptoms are prominent. Included in this group are those cases with sensory impairment. On the other hand, poisoning from snappers, groupers, and other piscivorous fishes produced a broader spectrum of symptoms, including cardiovascular disorders. Further studies are planned in an attempt to correlate different sets of symptoms with the different groups of toxic fishes.

ETIOLOGY

Eight of my cases have resulted from patients' eating two meals of different fish (at times the same species, at times not) one or two days apart. Judging from the lack of symptoms of other persons partaking of these meals, neither fish contained enough toxin to cause ciguatera alone, but together the two meals produced the toxemia, presumably by a summation effect.

Not infrequently I have observed that some individuals have been symptom-free after eating fish which has made other persons ill with ciguatera. In some cases this may involve a summation as discussed above. It also could result from persons eating different parts of a fish (we know that the different tissues harbor different levels of toxin). Undoubtedly it is at least in part due to natural variation in the response of different individuals to ciguatera toxin.

Some persons who have never been ill from ciguatera, in spite of several exposures to meals of fishes known to be toxic, believe that they have a natural immunity to such fish poisoning. While it is too early in our study of ciguatera to discount such claims, it would seem that a complete immunity is unlikely. In other words, if enough highly poisonous fish is consumed, even persons who think they are resistant to the effects of the toxin will become sick.

I have observed cases in which individuals appear to be sensitized to one or more kinds of fish and have more severe symptoms, especially neuro-

logic, than one would otherwise expect. Two cases have been clearly allergic. The onset of symptoms was rapid (a few minutes after the ingestion), and there were typical allergic manifestations, such as asthmatic crisis. Even a small amount of seafood can cause allergic reactions in persons sensitized to it.

DIFFERENTIAL DIAGNOSIS

Ciguatera should not be confused with histaminic poisoning or tetraodont (puffer) poisoning. I have seen 16 cases of fish poisoning of the histaminic type, most of which were caused by tunas and bonitos. This poisoning is a result of spoilage of the fish. The characteristic symptoms are a diffuse red rash with puffy face, edema of the eyelids, congestion of the conjunctival blood vessels, urticaria, and itching. A notable distinction from ciguatera is fever (38° C. or more). Also, all persons eating the offending fish exhibit symptoms at about the same time.

I made observations of two cases of tetraodont poisoning. Although some symptoms such as digestive upset, hypotension, and mydriasis may be similar to ciguatera, other symptoms such as tachycardia and unsystematized and transitory flaccid paralysis (we had no case of respiratory paralysis), clearly differentiate tetraodont poisoning.

TREATMENT

Treatment of ciguatera has been primarily symptomatic. We have used antispasmodics, and lactic bacilli for digestive disorders, salicylic acid-colchicine-B complex (B_1 , B_6 , B_{12}) for neurologic symptoms, antihistamines for itching, and cardiovascular analeptics, corticoids, and neosynephrin in case of shock or collapse.

Following the work of Li (1965)⁶ and Okihiro, Keenan, and Ivy (1965),⁷ I have treated 21 ciguatera patients in the hospital at Papeete with the cholinesterase reactivator "protopam chloride" (2-formyl 1-methyl pyridinium chloride oxime) in combination with atropine and B complex vitamins. A spectacular improvement followed a few hours after the rapid intravenous infusion of 250 cc of glucose solution containing 1 to 2 grams protopam chloride, 0.5 to 1 mg atropine, and a vitamin B complex with 250 mg vitamin B_6 (Bagnis,

1966).⁸ Only dysesthesia, myalgia, and slight itching persisted for three or four days. I have used such treatment primarily on the more severe cases, none of which was fatal. I observed that recovery is greatly enhanced when this treatment is given early.*

SUMMARY

Fish poisoning has been known in French Polynesia since ancient times. The majority of cases have been of the type termed ciguatera.

Observations were made of 350 ciguatera patients during the last three years. Three fatalities occurred but none was clearly the result of fish poisoning alone.

Considerable variation in symptomatology among these cases was apparent. The most common symptoms could be grouped into four categories: digestive, cardiovascular, neurologic, and general. For 112 of the cases the neurologic symptoms like paresthesia and dysesthesia were so pronounced that other symptoms were secondary. Digestive symptoms such as vomiting and diarrhea dominated in 58 cases. Itching predominated in 29 cases, and erythema in 14. Cardiovascular disorders were paramount in seven patients, and paresis of the lower limbs in another seven. Four cases displayed prominent dizziness, hallucinations, and nightmares.

There appears to be a difference in the cases of ciguatera following the ingestion of surgeonfishes (which are herbivorous) and carnivorous species such as groupers and snappers. Digestive and neurologic symptoms predominate in patients who become ill after eating surgeonfishes whereas the syndrome involves more symptoms, including cardiovascular disorders, when the carnivorous fishes were consumed.

Ciguatera treatment has been primarily symptomatic; however, considerable improvement was registered for 21 cases, mostly severe, when protopam chloride, atropine, and B complex vitamins were administered, particularly if soon after symptoms first appeared.

* While the effectiveness of this combination therapy remains clear, the role of protopam chloride has been questioned, since recent workers have been unable to repeat the original pharmacological observations on the protective action of this drug against ciguatoxin extracts. (Rayner, Kosaki & Fellmeth, *Science*, in press.)

REFERENCES

1. Banner, A. H.: Marine toxins from the Pacific. 1—Advances in the investigation of fish toxins. *Animal Toxins*. A collection of papers presented at the First International Symposium on animal toxins, pp. 157-165 (Apr.) 1966.
2. Belotte, J.: Les poissons "empoisonnés" du lagon tahitien. *Médecine Tropicale* 15:232-236 (Mar.-Apr.) 1955.
3. Randall, J. E.: A review of ciguatera fish poisoning with a tentative explanation of its cause. *Bull. of Marine Sc. of the Gulf and Carib.* 8:236-237 (Sept.) 1958.
4. Randall, J. E., and Brock, V. E.: Observations of the ecology of Epinepheline and Lutjanid fish of the Society Islands with emphasis on food habits. *Transaction American Fisheries Society* 89:9-16 (Jan.) 1960.
5. Ma'arde, L., Bagnis, R., Tapu, J., Bennett, J., and Nanai, F.: Une évaluation de l'importance des intoxications par les poisons vénéneux à Tahiti et leurs diverses conséquences. *Institut de Recherches Médicales de la Polynésie Française. Rapport Technique No. 1: 1-24* (Aug.) 1967.
6. Li, K. M.: Ciguatera fish poison: A potent cholinesterase inhibitor. *Science* 147: 1580 (Mar. 26) 1965.
7. Okihiro, M. M., Keenan, J. P., and Ivy, A. C., Jr.: Ciguatera fish poisoning and cholinesterase inhibition. Report of a case. *HAWAII MED. JOUR.* 24:353-361 (May-June) 1965.
8. Bagnis, R.: Contribution à l'étude de l'ichtyotoxisme en Polynésie Française. *Revue Internationale d'Océanographie Médicale*, T. 6-7, 89-110 (Sept.) 1967.

*Coumarin-type anticoagulants do inhibit fibrinolysis
in patients who have had myocardial infarction.*

The Effect of Coumarin-Type Anticoagulants on Blood Fibrinolysis

ROBERT C. MOELLERING, JR., M.D., GERALD ROSENBLATT, M.D.,
DAVID R. BASSETT, M.D., and JOSEPH STOKES, III, M.D., *Honolulu*

● *Plasma fibrinolytic activity measured by the euglobulin lysis time is diminished in patients receiving coumarin-type anticoagulants for myocardial infarction, as compared with a similar group of patients with healed myocardial infarction who were not receiving anticoagulant therapy, or with normal controls.*

MOST PUBLISHED reports dealing with the effect of the coumarin-type anticoagulants on blood fibrinolysis suggest that these drugs have little or no effect on fibrinolytic activity.¹⁻⁵ However, this finding has not been confirmed by all observers and several studies^{6,7} have suggested that fibrinolysis is inhibited by coumarin-type anticoagulants.

This report confirms the evidence that coumarin-type anticoagulants, when used for long-term therapy, do inhibit fibrinolysis.

MATERIAL AND METHODS

Subjects. The data on which this paper is based were obtained from 104 men, aged 37 to 69, examined as participants in the Hawaii Cardio-

vascular Study. All were of Hawaiian, part-Hawaiian, or Japanese ancestry, and all had experienced electrocardiographically proved myocardial infarction six months or more prior to the examination. Forty of them were receiving long-term anticoagulant therapy with coumarin-type drugs (in nearly all cases, warfarin sodium) at the time of the examination. None were receiving heparin.

The subjects reported as outpatients in the fasting state (having been instructed to eat nothing after the previous evening's meal), and blood was drawn between 7:00 and 7:30 A.M. for assay of plasma euglobulin fibrinolytic activity. In a number of subjects the assay was repeated between 11:00 and 11:30 A.M., three hours after eating an 85-gram-fat meal between 8:00 and 8:30 A.M. (Subjects weighing 86 Kg or more received a meal containing one gram of fat per kilogram.)

Similar studies were performed on 105 controls matched for age, sex, and race, who had been hospitalized within one year of their index case, and on 100 age-, sex-, and race-matched controls drawn at random from the general population. These subjects had no evidence of arteriosclerotic heart disease by history or electrocardiogram and were not receiving anticoagulants.

Fibrinolytic Activity. Plasma fibrinolytic activity was determined by the method of Kowalski *et al*⁸ as modified by Gajewski.⁹ Determinations were done in duplicate and lysis times were recorded

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TABLE 1.—Euglobulin lysis time (minutes)—fasting—7:00 A.M.

SUBJECTS WITH PREVIOUS MYOCARDIAL INFARCTION

	Total	Receiving Anticoagulant Therapy	Not Receiving Anticoagulant Therapy	"HOSPITAL" CONTROLS	"POPULATION" CONTROLS
	A	B	C	D	E
Number.....	104	40	64	105	100
Mean.....	239.3	263.7	224.0	213.5	218.4
Standard Error.....	5.28	7.48	6.54	5.01	5.06

P values: A vs. D, $P < 0.01$
A vs. E, $P < 0.01$
B vs. C, $P < 0.005$
C vs. D, $P > 0.05$
C vs. E, $P > 0.05$

to the nearest minute. Times of five hours or greater were recorded as 300 minutes. Technical error of the method was 3.2 minutes.

RESULTS

The mean fasting euglobulin lysis time (ELT) in those patients who had suffered acute myocardial infarction was 239.3 minutes (Table 1). This was significantly greater than the fasting ELT for either group of controls ($P < 0.01$). However, when the values of the 40 patients who were receiving anticoagulants were separated from those

of the 64 patients not receiving anticoagulants (Fig. 1), it was noted that those receiving anticoagulants had a significantly longer mean fasting ELT than those who were not receiving anticoagulants (263.7 vs. 224.0 minutes, $P < 0.005$). Moreover, while the mean ELT of the cases not receiving anticoagulants was somewhat longer than those of the controls (224.0 vs. 213.5 and 218.4 minutes), the difference was not statistically significant.

In order to conclude that the prolongation of the fibrinolysis time in the patients receiving anticoagulant therapy was due to their treatment, it is necessary to determine that this group did not significantly differ from the untreated in certain important parameters which have been described as affecting fibrinolytic activity. Both groups, as defined above, consisted of men with arteriosclerotic heart disease who had recovered from an electrocardiographically proved acute myocardial infarction. Relevant comparisons between the two groups are shown in Table 2. There was no significant difference in the average age or relative obesity (as measured by weight/height ratio) of the two groups. Thirty-five per cent of the treated group and 37.5 per cent of the untreated group were regular cigarette smokers at the time of examination, a difference which is not statistically significant. There was likewise no significant difference in the usual physical activity (as determined by history) of the two groups. Treated patients had a physical activity coefficient of 27.9, while the comparable value for untreated patients was 29.4. The prevalence of diabetes mellitus (here defined as history of diabetes mellitus or fasting blood glucose of 120 mg/100 ml or greater by the true glucose method) was 25.0 per cent in the group receiving anticoagulants and was 26.6 per cent in the untreated group. Peripheral vascular disease (as manifested by absent dorsalis pedis and posterior tibial pulses or intermittent claudication) was noted in two of the untreated patients, and was not seen in any of those receiv-

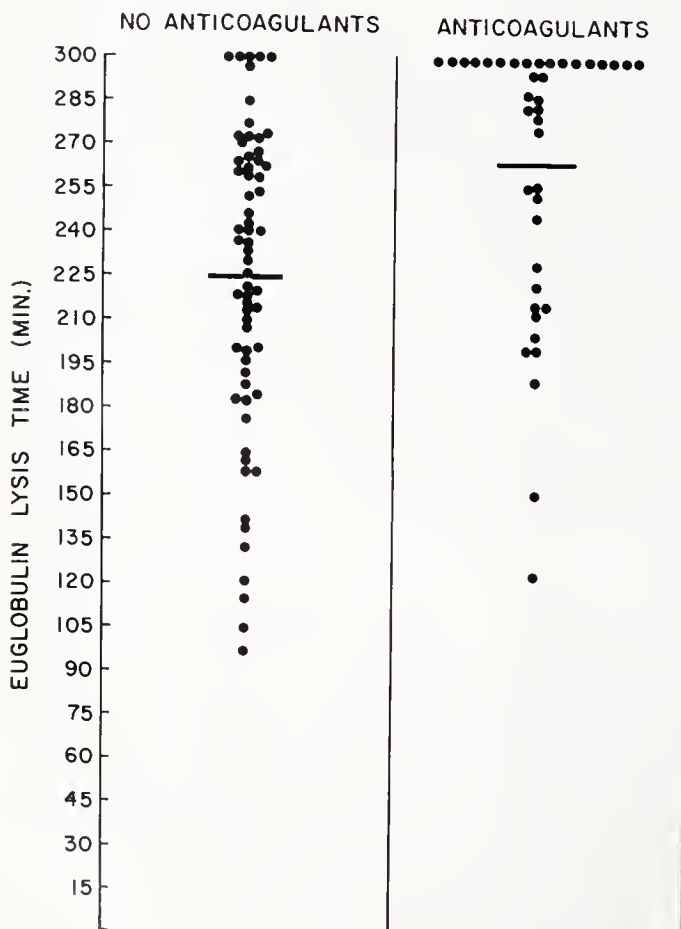


FIG. 1.—Scatter graph showing spread of euglobulin lysis time determinations in patients and controls not receiving anticoagulants, and in patients receiving anticoagulants.

TABLE 2.—Characteristics of subjects with previous myocardial infarction receiving coumarin-type anticoagulants as compared with those not receiving such therapy.

	MEAN AGE	MEAN WT. (LBS.): HT. (IN.) RATIO	PER CENT OF CASES OF DIABETES MELLITUS	PER CENT OF CASES REPORT- ING CIGA- RETTE SMOKING	PHYSICAL ACTIVITY COEFFI- CIENT*	RACIAL DISTRIBUTION		NO. OF CASES OF PERIPH- ERAL VASCULAR DISEASE	NO. OF CASES OF CEREBRO- VASCULAR DISEASE	MEAN IN- TERVAL SINCE MY- OCARDIAL INFARC- TION (YRS.)
						<i>Per Cent</i> <i>Hawai- ian</i>	<i>Per Cent</i> <i>Japa- nese</i>			
Receiving Anticoagulants.....	50.5	2.37	25.0	35.0	27.9	32.5	67.5	0	0	2.1
Not Receiving Anticoagulants.....	52.8	2.32	26.6	37.5	29.4	39.1	60.9	2	2	3.4
P.....	N.S.†	N.S.†	N.S.†	N.S.†	N.S.†	N.S.†	N.S.†	....	....	<0.001

* Computed from the following formula: Physical Activity Coefficient = ½ (average number of hours of sleep per day) + (average number of hours of sedentary activity per day) + 2 (average number of hours of light work per day) + 4 (average number of hours of heavy work per day).
† N.S. = P > 0.05.

ing anticoagulant therapy. Likewise, two of the untreated patients had cerebrovascular disease as manifested by previous cerebrovascular accident, while this was true of none of the treated group. Although the percentage of Hawaiians was slightly higher in the untreated group, the difference was not statistically significant.

The interval between myocardial infarction and examination was greater ($P < 0.001$) in those patients who were not receiving anticoagulant therapy (mean, 3.4 years) than in those receiving such treatment (mean, 2.1 years). However, when the treated and untreated groups were analyzed separately by chi square analysis, there was no significant correlation between ELT and the interval between myocardial infarction and examination (treated group: $\chi^2 = .303$, $P > 0.05$; untreated group: $\chi^2 = .786$, $P > 0.05$).

In all groups of subjects the mean ELT was shorter three hours after an 85-gram fat meal (11:00-11:30 A.M., Table 3) than it was in the fasting state (7:00-7:30 A.M., Table 1). As in the fasting state, the ELT in the patients receiving anticoagulant therapy was considerably longer than that of those not receiving this treatment (226.0 vs. 173.1 minutes, $P < 0.005$), and there was no statistically significant difference between the ELT of those patients who had suffered acute myocardial infarction and were not on anticoagulants (173.1 minutes) and that of the controls (164.6 and 187.8 minutes).

The effects of postprandial lipemia, or lack thereof, upon fibrinolysis will be the subject of a separate communication.

DISCUSSION

Although our results do not prove that the coumarin-type anticoagulants inhibit fibrinolysis, they strongly suggest that this may be the case. As far as could be determined, the two groups of patients with healed myocardial infarction were comparable in all significant respects except for the fact that one group was receiving anticoagulant therapy and the other was not. They did not differ significantly in age, relative obesity, cigarette smoking habits, general physical activity, prevalence of diabetes mellitus, or racial composition, factors which have previously been implicated as affecting fibrinolysis.¹⁰⁻¹⁶

The treated group did not contain more cases of clinical peripheral vascular disease or cerebrovascular disease, factors which could possibly account for a prolongation in fibrinolysis time;^{17, 18} in fact, those few instances of clinical peripheral vascular and cerebrovascular disease which did occur were all found in the untreated patients. There was a longer interval between myocardial infarction and time of examination in the untreated patients as compared to those receiving anticoagulation therapy, but there is no reason to suspect that this was responsible for the difference in fibrinolytic activity noted, particularly in view of

TABLE 3.—Euglobulin lysis time (minutes)—three hours after 85 gram fat meal—11:00 A.M.

	SUBJECT WITH PREVIOUS MYOCARDIAL INFARCTION					
	<i>Total</i>	<i>Receiving Anticoagulant Therapy</i>	<i>Not Receiving Anticoagulant Therapy</i>	"HOSPITAL" CONTROLS	"POPULATION" CONTROLS	
	A	B	C	D	E	
Number.....	54	20	34	67	100	
Mean.....	192.7	226.0	173.1	164.6	187.8	
Standard Error.....	7.70	12.67	8.20	5.09	5.24	
		P values: B vs. C, $P < 0.005$ C vs. D, $P > 0.05$ C vs. E, $P > 0.05$				

the fact that there was no correlation between ELT and the interval between myocardial infarction and examination when the treated and untreated groups were analyzed separately.

This study strongly suggests that the coumarin-type anticoagulants, particularly warfarin sodium, inhibit fibrinolysis as measured by the euglobulin method, confirming initial observations by Niewiarowska and Wegrzynowicz.⁷ Recent work by McKee *et al*⁶ has yielded similar results. Both of these groups assessed fibrinolytic activity by the euglobulin method, as we did. The fact that other studies¹⁻⁵ have failed to demonstrate an effect of the coumarin-type drugs on fibrinolysis might be accounted for by the fact that they have used alternate methods to assess fibrinolytic activity. Many of these studies, in addition, consist of only relatively few observations made on the acute effects of these drugs. It is possible that the inhibition of fibrinolysis we have noted is in part due to the long-term, as distinct from the short-term, use of the coumarin anticoagulants. It is also possible that other studies have not recognized this effect because of the small number of their observations.

Further and definitive studies are needed to determine whether coumarin-type anticoagulants cause true inhibition of fibrinolytic activity, particularly as measured by methods other than the

euglobulin lysis time and in vivo. If they do inhibit fibrinolysis as our data suggest, it will be necessary to review the findings of those studies reporting diminished fibrinolytic activity in patients with coronary heart disease, peripheral vascular disease, pulmonary infarctions, and other diseases where the case groups contained a significant number of patients receiving anticoagulant therapy. In addition, if coumarin-type anticoagulants inhibit fibrinolysis, this is a factor to merit serious consideration when assessing their value in preventing thrombosis, and it may account for the fact that many studies have failed to show significant benefit from the long-term use of coumarin-type anticoagulants.

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REFERENCES

1. Ellison, R. C., and Brown, J.: Fibrinolysis in pulmonary vascular disease, *Lancet* 1:786-788 (Apr. 10) 1965.
2. Fearnley, G. R.: Fibrinolysis, Williams & Wilkins Co., Baltimore, 1965, p. 101.
3. Lackner, H., and Merskey, C.: Variation in fibrinolytic activity after acute myocardial infarction and after the administration of oral anticoagulant drugs and intravenous heparin, *Brit. J. Haemat.* 6:402-413 (Oct.) 1960.
4. Ogston, D.: The effect of phenindione on plasma fibrinolytic activity, *Scot. Med. J.* 6:565-566 (Dec.) 1961.
5. Ogston, D., and Fullerton, H. W.: Plasma fibrinolytic activity following recent myocardial and cerebral infarction, *Lancet* 2:99-101 (July 17) 1965.
6. McKee, P., Ciccarelli, M., and Kannel, W.: (Abstract) Studies of the Euglobulin Lysis Time. The Framingham Study, Proceedings of the Clinical Society and Commissioned Officers Association USPHS 1:17 (May) 1966.
7. Niewiarowska, M., and Wegrzynowicz, Z.: Influence of dicoumarol derivatives on plasma fibrinolytic system, *Thromb. Diath. Haemorrh.* 3:279-285, 1959.
8. Kowalski, E., Kopec, M., and Niewiarowski, S.: An evaluation of the euglobulin method for the determination of fibrinolysis, *J. Clin. Path.* 12:215-218 (May) 1959.
9. Gajewski, J.: Effect of the ingestion of various fats on the fibrinolytic activity in normal subjects and patients with coronary heart disease, *J. Atheroscler. Res.* 1:222-228 (May-June) 1961.
10. Chakrabarti, R., et al: Fibrinolytic activity related to age in survivors of myocardial infarction, *Lancet* 1:573-574 (Mar. 12) 1966.
11. Fearnley, G. R.: Fibrinolysis, Williams & Wilkins Co., Baltimore, 1965, pp. 68-71.
12. Fearnley, G. R., Chakrabarti, R., and Avis, P.R.D.: Blood fibrinolytic activity in diabetes mellitus and its bearing on ischaemic heart disease and obesity, *Brit. Med. J.* 1:921-923 (Apr. 6) 1963.
13. Kontinen, Y. P.: Activation of the fibrinolytic system in human blood by streptokinase and changes in this system and in the euglobulin clot lysis time in relation to age and sex. II. Parameters of fibrinolysis in relation to age and sex, *Scand. J. Clin. Lab. Invest.* 17 (Suppl. 82):45-46, 1965.
14. Moellering, R. C., Jr., Rosenblatt, G., Stokes, J., III, and Bassett, D. R.: Euglobulin and dilute whole blood fibrinolysis in Japanese and Hawaiian males, unpublished data.
15. Ogston, D., and McAndrew, G. M.: Fibrinolysis in obesity, *Lancet* 2:1205-1207 (Dec. 5) 1964.
16. Sogani, R. K., and Joshi, K. C.: Effect of cigarette and biri smoking & tobacco chewing on blood coagulation and fibrinolytic activity, *Indian Heart J.* 17:238-242 (July) 1965.
17. Nestel, P. J.: Fibrinolytic activity of the blood in intermittent claudication, *Lancet* 2:373-374 (Sep. 19) 1959.
18. Mathur, K. S., Wahal, P. K., and Singhal, R. K.: Fibrinolytic activity of blood in occlusive cerebrovascular disease and its relationship with serum lipids, *J. Ass. Physicians India* 13:303-311 (May) 1965. ■

Comparison of VDRL, RPCF, and FTA-ABS Tests for Syphilis

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● *The Fluorescent Antibody Absorption Test (FTA-ABS) is the test of choice in the serologic diagnosis of syphilis, because it is highly sensitive and specific throughout all stages of the disease, gives a minimum of false reactions as compared to other tests, and can be performed in any laboratory having fluorescent microscopy facilities and personnel with a reasonable degree of training.*

CURRENTLY ACCEPTED techniques most widely employed for the serodiagnosis of syphilis are the VDRL (Venereal Disease Research Laboratory) flocculation test, the RPCF (Reiter Protein Complement Fixation) test, and the TPI (Treponema Pallidum Immobilization) test. Provided in logical sequence, they constitute the "triple test plan": the rapid and least expensive VDRL test for routine screening; the relatively inexpensive RPCF for the differentiation of treponemal antibody from biological false positive (BFP) reactions; and the highly expensive, complex, exacting and time-consuming TPI test as the ultimate reference for the serologic diagnosis of syphilis.

The VDRL test, which employs a (nontreponemal) cardiolipin-lecithin antigen, has been severely criticized for its lack of specificity, although it is used extensively as a practical screening test for syphilis and in follow-up determinations of serum reagin levels. The antigen used in the RPCF test is a protein derived from the nonpathogenic, culturable Reiter treponeme, whereas the antigen

employed in TPI is a viable, pathogenic Nichols strain of *Treponema pallidum*.

Today there is considerable interest in the FTA-ABS (Fluorescent Treponemal Antibody Absorption) test because of its excellent sensitivity and specificity, with the additional advantages of relative simplicity, low cost, and speed of performance.

This absorption procedure is a decided improvement over the FTA-5 test (serum dilution of 1:5). This test, first described by Deacon *et al*¹ in 1957, was later found to be too sensitive, so that it also reacted nonspecifically with many normal sera. A subsequent modification in 1960, the FTA-200 test, designed to improve the specificity by diluting the serum to 1:200, resulted in a highly specific test but one which lacked seriously in sensitivity.²

Demonstration by Deacon and Hunter³ in 1962 that some normal sera contain Reiter antibody (which reacts with common antigens shared by both pathogenic and saprophytic treponemes), and that it can be removed by appropriate absorption procedures, led these investigators to devise, in 1964, the FTA-ABS tests.⁴ In this test, sonic-disrupted Reiter treponemes are used as a sorbent to remove or block the cross-reacting, nonspecific Reiter antibodies. This absorption procedure thus permitted the return to the 1:5 serum dilution to recoup both the specificity and sensitivity.

The FTA-ABS test may replace the TPI test completely. Smith and Taylor⁵ encountered serologic reactivity only in the FTA-ABS test in several instances of late ocular syphilis and neurosyphilis. Stevens *et al*⁶ examined 102 sera by the RPCF, TPI, and FTA-ABS tests and concluded the FTA-ABS test to be superior to both the other tests in both sensitivity and specificity. Following the findings of these investigators, the New York

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TABLE 1.—VDRL, RPCF, and FTA-ABS test results on 1,700 selected serum specimens.

	TEST RESULTS			NUMBER SPECI- MENS	PER CENT
	VDRL	RPCF	FTA-ABS		
All three tests in agreement (51.4%)	R	R	R	652	38.3
	N	N	N	223	13.1
	R	N	N	304	17.9
Tests not in agreement (48.6%)	R	N	R	329	19.4
	R	R	N	31	1.8
	N	R	R	59	3.5
	N	R	N	80	4.7
	N	N	R	22	1.3
TOTAL				1,700	100.0

R = Reactive N = Nonreactive

State Health Department discontinued TPI test service in 1966.⁷

False negative TPI tests in syphilis were further documented by Smith⁸ in 1967. Atwood *et al.*,⁹ Beam *et al.*,¹⁰ Bradford *et al.*,¹¹ Deacon *et al.*,¹² Knox *et al.*,¹³ Moor and Knox,¹⁴ and Wood *et al.*¹⁵ concluded from their studies that the FTA-ABS procedure has a comparable level of specificity but is more sensitive than the TPI test in all stages of syphilis, particularly primary syphilis and syphilis of long duration.

The Laboratories Branch of the Hawaii Department of Health provides both the VDRL and RPCF tests routinely. The present studies were designed to compare the sensitivity of the VDRL, RPCF, FTA-200, and FTA-ABS tests performed on blood specimens submitted to the Serology Laboratory for routine serologic tests for syphilis. We could not evaluate the specificity of these tests since there was no contact with the patients nor were the clinical, epidemiological, and other essential histories obtained.

MATERIALS AND METHODS

The comparative tests were conducted from January, 1966, through December, 1967. The specimens selected for testing included those that were found reactive in the VDRL screening test and those which were accompanied with a specific request by the physicians for either the RPCF or the FTA-ABS test. In any event, only the specimens with adequate volume for all four tests were selected. From February through December, 1967, the selection was limited only to those requested for the FTA-ABS test.

The VDRL, the RPCF (Kolmer one-fifth volume), and the FTA-200 tests were performed as described in the 1964 *Manual of Serologic Tests for Syphilis*¹⁶ and the FTA-ABS test in accordance with the 1965 *Provisional Technique for the*

*Fluorescent Antibody Absorption (FTA-ABS) Test.*¹⁷

The VDRL and RPCF tests were done in the Syphilis Serology Laboratory and the FTA-200 and FTA-ABS in the Special Services Laboratory, thus involving two separate groups of personnel. Reagents were obtained from commercial sources and each lot was checked or standardized against reference materials supplied by the Venereal Disease Research Laboratory, NCDC. The fluorescence microscopy unit consisted of a Fluorolume Illuminator (AO 645) with HBO-200 Osram lamp and an AO Spencer Fluorostar microscope. Filter combination used was a Schott BG-12 3-mm exciter filter and an OG-1 barrier filter.

RESULTS AND DISCUSSION

The results of the VDRL, RPCF, and FTA-ABS tests on 1,700 serum specimens are given in Table 1. Remember that a major portion of these specimens were selected on the basis of their being reactive in the VDRL screening test.

Of the 1,700 serum specimens tested by the three techniques, total agreement was found in 875 or 51.4 per cent and disagreement in 825 or 48.6 per cent. Such disagreement is to be expected, since these tests employ different antigens, as discussed previously and therefore detect different antibodies. Altogether, the VDRL test was reactive in 1,316 or 77.4 per cent of the specimens, the FTA-ABS in 1,062 or 62.5 per cent, and the RPCF in 822 or 48.4 per cent.

It is to be remembered that the VDRL test employs a nonspecific antigen (cardiolipin) and thus may be expected to pick up some false positives and show higher sensitivity. The treponemal antigens, on the other hand, can be expected to be more specific in their reactions, and thus have a lower sensitivity rating than the VDRL test. In the establishment of a diagnosis of syphilis, however, a greater significance is placed on the reactions with treponemal antigens.

Table 1 shows that 304 or 17.9 per cent of the total specimens examined were VDRL reactive but nonreactive by both the RPCF and FTA-ABS tests. These may very well be designated as biologic false positives (BFP); they constituted 45.8 per cent of the VDRL reactive specimens in the disagreement group or 17.9 per cent of the total specimens tested. Of particular significance are the 329 specimens (49.5 per cent in the disagreement group or 19.4 per cent of the total specimens examined) which were not reactive by the RPCF test but were found to be reactive by FTA-ABS test and would have been missed if this test had not been used.

TABLE 2.—RPCF and FTA-ABS reactivity compared with VDRL reactivity.

VDRL	NO. SPECI- MENS	REACTIVE IN			
		RPCF	(%)	FTA-ABS	(%)
Reactive	1,316	683	(51.9)	981	(74.5)
Nonreactive	384	139	(36.2)	81	(21.1)
TOTAL	1,700	822	(48.4)	1,062	(62.5)

A comparison of RPCF and FTA-ABS reactivities in relation to the VDRL is shown in Table 2. Of the total of 1,316 VDRL reactive specimens, RPCF was reactive in 683 or 51.9 per cent and FTA-ABS in 981 or 74.5 per cent. Of the 384 VDRL nonreactive specimens, RPCF was reactive in 139 or 36.2 per cent, and FTA-ABS in 81 or 21.1 per cent.

Table 3 compares the FTA-ABS reactivity with those of VDRL and RPCF. Of the total of 683 specimens reactive in both VDRL and RPCF, 652

TABLE 3.—Comparison of FTA-ABS reactivity with VDRL and RPCF tests.

VDRL	RPCF	NO. SPECI- MENS	Reac- tive	FTA-ABS	
				(%)	Nonre- active (%)
R	R	683	652	(95.5)	31 (4.5)
R	N	633	329	(52.0)	304 (48.0)
N	N	245	22	(9.0)	223 (91.0)
N	R	139	59	(42.4)	80 (57.6)

or 95.5 per cent were reactive in FTA-ABS test. This leaves 31 or 4.5 per cent reactive with Reiter antigen (RPCF) but not with the pathogenic Nichols strain of *Treponema pallidum*. There were 633 specimens which were VDRL reactive but RPCF nonreactive. Of this group, 329 or over one-half (52.0 per cent) reacted in the FTA-ABS test.

Nonreactivity in the VDRL and RPCF tests does not exclude the presence of syphilis antibodies. This is shown by the nine per cent of the 245 specimens nonreactive in both the VDRL and RPCF tests which were, however, reactive in the FTA-ABS test. If all the 384 VDRL nonreactive specimens were taken into consideration, this figure is further increased to 21.1 per cent. In this connection, it is of interest to note the work of Harner *et al*¹⁸ who, in their study of FTA-ABS test in late syphilis, encountered among 718 FTA-ABS reactors 277, or 39 per cent, who were nonreactive to the VDRL test.

Of the 1,316 VDRL-reactive specimens, 558, or 42.4 per cent, were only weakly reactive (WR). As shown in Table 4, 228, or 40.9 per cent, of these WR specimens were reactive in both the RPCF and FTA-ABS tests and 165, or 29.6 per cent, nonreactive in both tests. However, the

TABLE 4.—Comparison of RPCF and FTA-ABS reactivities on 558 VDRL weakly reactive specimens.

RPCF	R	FTA-ABS	
		N	Total
R	228	16	244
N	149	165	314
TOTAL	377	181	558

RPCF test failed to detect 149 or 26.7 per cent of the WR specimens which were reactive by the FTA-ABS test. Only 16 or 2.9 per cent were reactive by RPCF test but nonreactive by the FTA-ABS test. Thus, in general, the RPCF in relation to FTA-ABS test seems to give highly specific results, but its value is seriously limited by its lack of sensitivity.

During the course of this study, the FTA-200 test was performed on 1,203 specimens in addition to the VDRL, RPCF, and FTA-ABS tests. The findings are summarized in Table 5. Reactivity

TABLE 5.—Reactivity rates of FTA-ABS compared with FTA-200.

VDRL	RPCF	NO. SPECI- MENS	REACTIVE IN			
			FTA-ABS (%)	FTA-200 (%)		
R	R	551	524 (95.1)	478 (86.8)		
R	N	400	193 (48.3)	128 (32.0)		
N	N	137	8 (5.8)	12 (8.8)		
N	R	115	40 (34.8)	25 (21.7)		
TOTAL		1,203	765 (63.6)	643 (53.4)		

rates were FTA-ABS 63.6 per cent, FTA-200 53.4 per cent, and RPCF 55.4 per cent.

It is further shown in Table 6 that 146 of these specimens were nonreactive by the FTA-200 test but reactive by the FTA-ABS test and 24 specimens reactive by FTA-200 but nonreactive by FTA-ABS test. The sensitivity of the FTA-200 test in relation to the FTA-ABS test was only

TABLE 6.—FTA-200 test results compared with FTA-ABS test.

FTA-200	R	FTA-ABS	
		N	Total
R	619	24	643
N	146	414	560
TOTAL	765	438	1,203

80.9 per cent. Since the FTA-200 test had no additional advantages, this service was discontinued in February, 1967.

Of the total 1,700 specimens tested, 345 or 20.3 per cent were repeat specimens. Among these, the reactivity patterns were the same as in the first specimen in 224 involving 165 individuals. This

TABLE 7.—VDRL, RPCF, and FTA-ABS results in repeat specimens.

A. Pattern the same as in initial specimen:

VDRL	PATTERN		NUMBER INDIVIDUALS	NUMBER SPECIMENS	INTERVALS OF SPECIMEN COLLECTION IN WEEKS
	RPCF	FTA-ABS			
R	R	R	85	119	1 to 52
R	N	R	31	43	1 to 78
R	N	N	32	37	1 to 82
N	R	R	4	7	1 to 22
N	R	N	5	7	1 to 11
N	N	N	8	11	1 to 30
TOTAL			165	224	

B. Pattern differed in repeat specimen:

TEST	NUMBER INDIVIDUALS	GAIN*		Intervals, Weeks	LOSS**		Intervals, Weeks
		Number Individuals	Number Specimens		Number Individuals	Number Specimens	
VDRL	18	5	7	2 to 11	13	25	2 to 16
RPCF	52	16	21	3 to 52	36	54	1 to 28
FTA-ABS	11	5	9	4 to 20	6	6	4 to 25
TOTAL	81	26	36		55	85	

* Gain = result reactive in repeat specimen whereas the initial specimen was nonreactive.
 ** Loss = result nonreactive in repeat specimen whereas the initial specimen was reactive.

is shown in Table 7. A large majority of these were the second specimens obtained within one to eight weeks. In some instances, however, the intervals were much longer with third, fourth, or more repeat specimens.

Patterns varied from the initial specimen in 121 repeat specimens taken from 81 individuals. The greatest inconsistency occurred with the RPCF test with 16 "gains" (nonreactive first specimen, reactive follow-up specimen) and 36 "losses" (reactive first specimen, nonreactive subsequent specimen). It is not possible to state whether this is due to the test proper (reproducibility) or actually due to fluctuations in the antibody titers. It is suspected, however, that the low sensitivity of the RPCF test contributed greatly to this inconsistency.

SUMMARY

It is evident from the results of our studies that the FTA-ABS technique should prove to be a most valuable tool and provide considerable aid in the diagnosis and control of syphilis. In addition to being far more sensitive than the RPCF test, it bears special significance in situations where biologic false reactions are suspected or if there is suggested evidence of syphilis and the STS reports are nonreactive.

The FTA-ABS test should prove to be a welcome procedure to laboratories where the conventional complement fixation test cannot be performed because of unavailability of sheep cells and where the TPI test is out of the question because of its high cost and complexity.

REFERENCES

- Deacon, W. E., Falcone, V. H., and Harris, A.: A fluorescent test for treponemal antibodies, *Proc. Soc. Exp. Biol. Med.* 96:447-480 (Aug.) 1957.
- Deacon, W. E., Freeman, E. M., and Harris, A.: Fluorescent treponemal antibody test. Modification based on quantitation (FTA-200), *Proc. Soc. Exp. Biol. Med.* 103:827-829 (Apr.) 1960.
- Deacon, W. E. and Hunter, E. F.: Treponemal antigens as related to identification and syphilis serology, *Proc. Soc. Exp. Biol. Med.* 110:352-356 (June) 1962.
- Hunter, E. F., Deacon, W. E., and Meyer, P. E.: An improved FTA test for syphilis, the absorption procedure (FTA-ABS), *Public Health Rep.* 79:410-412 (May) 1964.
- Smith, J. L., and Taylor, W. H.: The FTA-ABS test in ocular and neurosyphilis, *Amer. J. Ophthal.* 60:653-658 (Oct.) 1965.
- Stevens, R. W., Boylan, J., and Memoli, A. J.: A note on the fluorescent treponemal antibody—absorption (FTA-ABS) test, *Amer. J. Clin. Path.* 47:408-409 (Mar.) 1967.
- Stevens, R. W., Boylan, J., and Memoli, A. J.: Fluorescent treponemal antibody—absorption (FTA-ABS) test for syphilis, N.Y. Dept. of Health, Div. of Laboratories and Research, *Ann. Rpt.* for 1966, p. 126.
- Smith, J. L.: The false-negative treponema pallidum immobilization test in syphilis: pseudobiologic false-positive syndrome, *JAMA* 199:128-129 (Jan. 9) 1967.
- Atwood, W. G., Miller, J. L., Stout, G. W., and Norins, L. C.: The TPI and FTA-ABS tests in treated late syphilis, *JAMA* 203: 107-109 (Feb. 19) 1968.
- Beam, W. E., Jr., Dedeaux, J. D., and Humes, J. J.: An evaluation of the FTA-ABS test for syphilis, *Amer. J. Clin. Path.* 47:404-407 (Mar.) 1967.
- Bradford, L. L., Tuffanelli, D. L., Puffer, J., Bissett, M. L., Bodily, H. L., and Wood, R. M.: Fluorescent treponemal absorption and treponema pallidum immobilization tests in syphilitic patients and biological false-positive reactors, *Amer. J. Clin. Path.* 47:525-532 (Apr.) 1967.
- Deacon, W. E., Lucas, J. B., and Pride, E. V.: Fluorescent treponemal antibody—absorption (FTA-ABS) test for syphilis, *JAMA* 198:156-160 (Nov. 7) 1966.
- Knox, J. M., Short, D. H., Wende, R. D., and Glicksman, J. M.: The FTA-ABS test for syphilis. Performance in 1,033 patients, *Brit. J. Vener. Dis.* 42:16-20 (Mar.) 1966.
- Moore, M. D., Jr., and Knox, J. M.: Sensitivity and specificity in syphilis serology: clinical implications, *Southern Med. J.* 58:963-968 (Aug.) 1965.
- Wood, R. M., Inouye, Y., Argonza, W., Bradford, L., Jue, R., Jeong, Y., Puffer, J., and Bodily, H. L.: Comparison of the fluorescent treponemal antibody absorption and treponema pallidum immobilization tests on serums from 1182 diagnostic problem cases, *Amer. J. Clin. Path.* 47:521-524 (Apr.) 1967.
- Serologic tests for syphilis, 1964 Manual, Venereal Disease Branch, NCDC, USPHS, Atlanta, Ga., Public Health Serv. Publication No. 411 (May) 1964.
- Provisional technique for the fluorescent treponemal antibody—absorption (FTA-ABS) test, *Venereal Dis. Res. Lab., NCDC USPHS, Atlanta, Ga.*, pp. 9 (Sept. 20) 1965.
- Harner, R. E., Smith, J. L., and Israel, C. W.: The FTA-ABS test in late syphilis, *JAMA* 203:103-106 (Feb. 19) 1968. ■

True dextrocardia is harder to document than you might suppose. Reversal of the P loop in the VCG is diagnostic.

The P Loop Rotation, a Vectorcardiographic Sign of Dextrocardia

JOSEPH G. ELLIS, M.D., and
HELEN M. ONO, Honolulu

● *Clockwise rotation of the P loop in a frontal-plane vectorcardiogram is shown in three cases to be a distinctive and critical sign of dextrocardia.*

AMONG the different ways of graphically confirming a clinical diagnosis of dextrocardia, a most reliable sign is the direction of inscription of the frontal plane P loop of the vectorcardiogram (VCG), provided the P wave originates from the sinus node. In the normally situated heart the right atrium lies to the right and anterior to the left atrium and in the normal course of atrial activation the frontal-plane P loop can be seen to travel in a counter-clockwise direction.¹⁻³ In dextrocardia there is mirror-image rotation of all chambers and atrial activation, as seen in the frontal-plane P loop, travels in a clockwise direction.¹ Displacement of the heart into the right chest (dextroposition) and severe right heart overloading from chronic lung disease may partly simulate physical, radiologic, or electrocardiographic findings of true dextrocardia, but the reversal of direction of the frontal-plane P loop will

remain a distinguishing sign. The following three cases illustrate this point.

METHODS

Only the frontal-plane VCG's are shown, and these have been deliberately blown up to show the P loop to advantage. The Frank lead system was used. Tracings were photographed from the auxiliary screen for VCG of a model DR-8 Electronics for Medicine Simultrace Recorder with time dashes of .004 seconds distorted into a teardrop shape so that the leading edge is pointed and the trailing edge is blunt. Calibration was adjusted so that 1 MV equalled 20 cm deflection.

CASES

CASE 1. A 16-year-old girl, examined because of a minor illness, was found to have uncomplicated dextrocardia. The blood pressure and peripheral pulses were normal. The heart sounds were normal and there were no murmurs. There was also situs inversus of other viscera. Her chest x-ray, EKG, and VCG are shown (Figures 1, 2, 3).

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FIG. 1. (Case 1)—Chest x-ray: dextrocardia with situs inversus. FIG. 2. (Case 1)—The electrocardiogram is normal except for dextrocardia. FIG. 3. (Case 1)—The magnified frontal plane VCG shows the P loop inscribed in a clockwise direction.

CASE 2. A 16-year-old girl with dextroposition of the heart was seen because of hypoplasia of the right lung due to absence of the right pulmonary artery. The blood pressure was normal. Heart sounds were normal and there were no murmurs. Cardiac catheterization and pulmonary angiography showed absence of the right pulmonary artery, but the heart was otherwise normal. Her chest x-ray, EKG, and VCG are shown (Figures 4, 5, 6).

CASE 3. A 44-year-old man with chronic pulmonary emphysema and cor pulmonale presented signs of chronic obstructive airway disease. There was a palpable right ventricular heave, and a right ventricular gallop sound could be heard over the xiphoid process. He had an enlarged liver and edema of the lower extremities. His chest x-ray, EKG, and VCG are shown (Figures 7, 8, 9).

DISCUSSION AND COMMENT

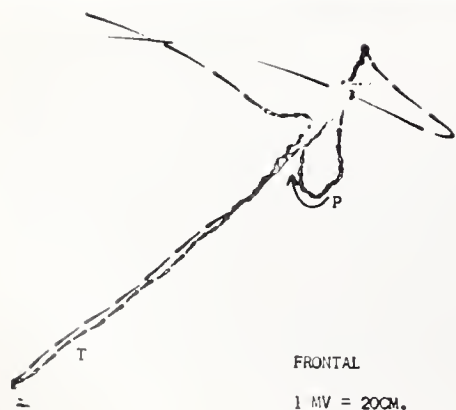
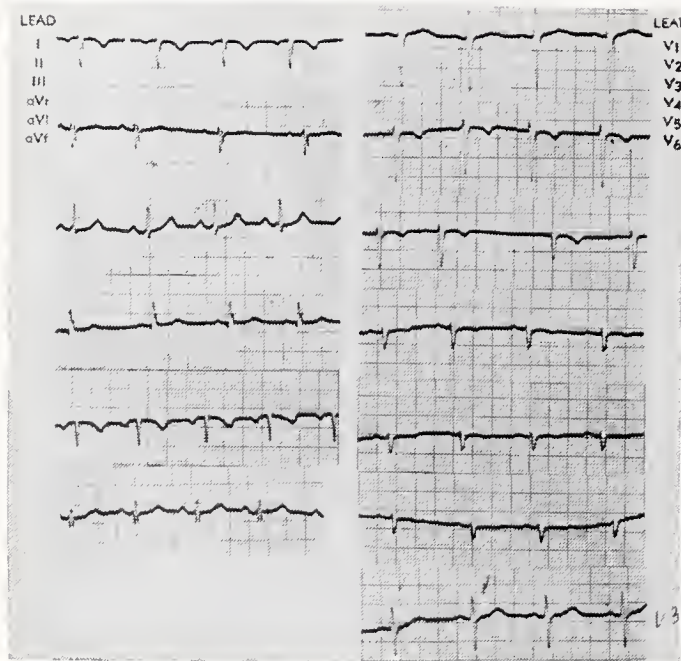
The electrocardiogram is a scalar tracing with voltage on the ordinate and time on the abscissa. The vectorcardiogram is a static tracing of the leading edges of instantaneous resultant vectors created by depolarization and repolarization, and it appears as loops corresponding to the P, QRS, and T waves of the EKG. Much the same information is contained in each type of tracing, except that the VCG gives the direction of rotation (clockwise and counterclockwise) of P, QRS, and T waves in addition to their magnitude and electrical axis.

In the three cases shown the mean axis of each of the P loops is approximately the same, directed at 90 degrees using standard frontal-plane axis coordinates. The magnitudes are all within normal limits.² Clockwise rotation, however, distinguishes the case of dextrocardia. Neither displacement of the heart into the right chest in case 2, nor marked hypertrophy of the right heart in case 3, vitiates this vectorcardiographic sign of mirror-image rotation of the heart, reflecting as it does the reversed anatomic relation of right and left atria.

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REFERENCES

1. Chou, T. C., and Helm, R. A.: Clinical vectorcardiography, Grune and Stratton, 1967.
2. Sano, T., Hellerstein, H. K., and Vayda, E.: P vector loop in health and disease as studied by the technique of electrical dissection of the vectorcardiogram, *Amer. Heart J.* 53:854 (June) 1957.
3. Forkner, C. E., Hugenholtz, P. G., and Levine, H. D.: The vectorcardiogram in normal young adults, *Frank Lead System*, *Amer. Heart J.* 62:237 (Aug.) 1961.



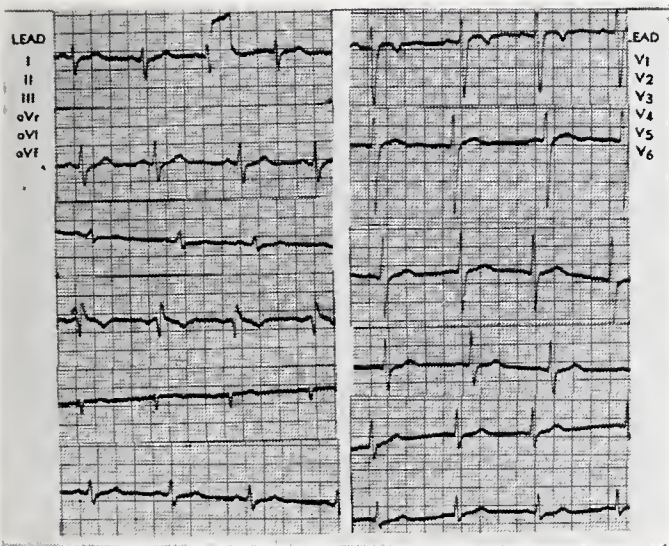
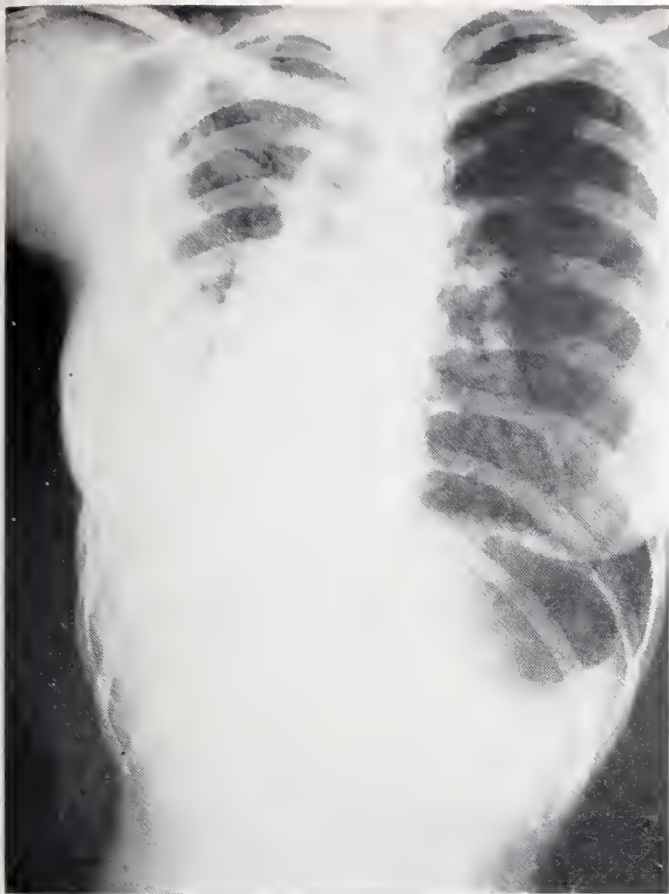
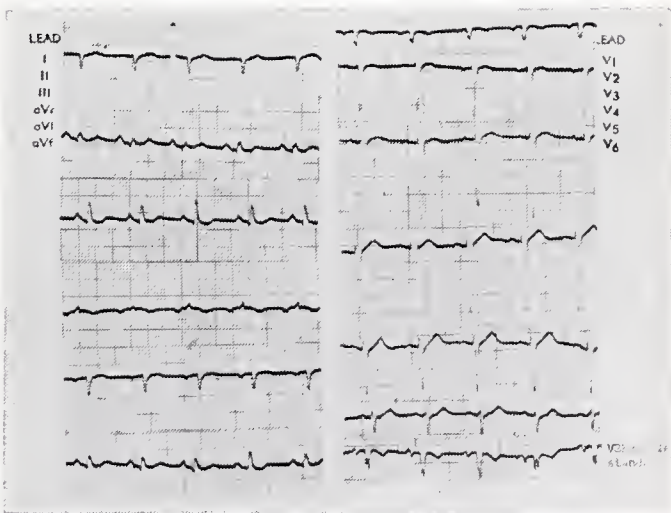


FIG. 4. (Case 2)—There is dextroposition of the heart. FIG. 5. (Case 2)—The electrocardiogram shows an S1, S2, S3 pattern with normal P waves. FIG. 6. (Case 2)—The magnified frontal-plane VCG shows the P loop inscribed in a counterclockwise direction. FIG. 7. (Case 3)—The chest x-ray is not remarkable. FIG. 8. (Case 3)—The electrocardiogram shows marked right axis deviation and posterior rotation in the precordial leads consistent with chronic lung disease and right ventricular hypertrophy. FIG. 9. (Case 3)—The magnified frontal-plane P loop is inscribed in a counterclockwise direction.





The President's Page



"Today the name of the game is Participation." More and more the public, and individuals, are asked to participate in this endeavor and that endeavor. They are asked to participate in fund-raising drives for this organization and that organization. We do not minimize the efforts of these groups and individuals. Nor do we imply that participation is anything but good. It is quite obvious that our society will not allow us physicians to lead individual and secluded lives. We must realize that we are a part of society, and as such, we are expected to participate in actions which will affect the course and promote the well-being of society in general. Society is made up of individual citizens and all physicians are a part of this citizenry.

But it is not my intent to comment on participation as a member of society. Other more capable lecturers and individuals have expounded this theme, and I am sure that you will gain more from listening to them than reading my comments on this subject. However, the word participation leads me to a brief discussion on the AMA regarding medical society participation in government medical care programs. The Council on Medical Service report regarding medical society participation in government medical programs was adopted as amended by the House of Delegates. This report set forth five recommendations which provide guidelines to medical societies.

- State and local medical societies should assume active, responsible leadership in reviewing and setting standards for existing health services in their communities and in the evaluation, planning, developing, improvement, and augmentation of appropriate existing and new services.

- State and local medical societies may accept governmental funds including federal funds . . . but only when such funds are essential for the society to maintain its proper role in the development of community health services and when formal agreements permit the society authority over the provisions of medical care in accordance with the Principles of Medical Ethics.

- When certain criteria are met, a state or local medical society may enter into agreements with government agencies to administer health care programs and to have the administrative costs of such programs financed from governmental funds. . . . The society should use some mechanism such as a nonprofit corporation or other entity, separate from the society itself, and serviced by an independent administrative staff, where possible. . . .

- Personal care is primarily an individual responsibility and federal aid in financing care for those unable to pay should be provided only in conjunction with other levels of government—community, county, and state. In individual situations, federal grants for research, demonstration, or pilot projects in services may be permissible. . . .

- There are hazards to the medical society in involvement in government programs, . . . and such involvement should be undertaken only after detailed study and review by the members. . . . The society should have a voice in the planning, and any change in the society's role should be conditioned on prior review and consent by the society. Any contractual agreements entered into by the society should be for specific, limited periods of time, preferably not more than one year, and should be renewable only on agreement by the society.

In accepting the above recommendations, the AMA has *not* given blanket endorsement to governmental programs in the field of health care, but has clarified its position regarding reimbursement by governmental agencies to state and local medical societies engaged in planning, development, or administration of programs meeting previously adopted standards of acceptability.

Robert W. McGowan

The Clinical Professor

In a day before the supremacy of the full-time professor in medical schools had become established, the advantages of the clinical professor, the part-time teacher who is also engaged in the hurly-burly of private practice of medicine, were recounted with his customary eloquence and vigor by the renowned William Osler, in a letter written to the President of Johns Hopkins Medical School.

Wrote Osler:

In life, in work, in word, and in deed, [the Director of the University Clinic] is an exemplar to the young men about him, students and assistants. "Cabined, cribbed, confined" within the four walls of a hospital, practicing the fugitive and cloistered virtues of a clinical monk, how shall he, forsooth, train men for a race the dust and heat of which he knows nothing of and—this is a possibility!—cares less? I cannot imagine anything more subversive to the highest ideal of a clinical school than to hand over young men who are to be our best practitioners to

a group of teachers who are ex officio out of touch with the conditions under which these young men will live. The clinical teachers belong to the fighting line of the profession, whose ambitions and activities they should share and direct. Do you imagine for a moment that men whose interests are mainly in the research aspects of medicine, and who have no touch with the rank and file—the men behind the guns—do you suppose they would get into the arena and share the struggle of their brethren?

Even though it has been decided that the advantages possessed by the full-time teacher outweigh these disadvantages, it may be well to remind ourselves once again that so great and thoughtful a physician and teacher as William Osler thought well of the part-time teacher.

It may be well, too, to keep in mind that 95 per cent of medicine is practiced in offices, dispensaries, and homes, and not in the hospitals, university or otherwise, whither so much of medical teaching seems to gravitate.

Chinese Restaurant Syndrome

The Chinese Restaurant Syndrome, or post-sino-cibal syndrome, discussed in the April 4 issue of the *New England Journal of Medicine* by Dr. Ho Man Kwok, consists of a burning sensation in the back of the neck, extending to the arms and chest, beginning 15 to 30 minutes after eating a meal in a Chinese restaurant. This is followed by a feeling of infraorbital pressure and tightness, and often some substernal discomfort. No skin lesions appear.

It is suggested by Schaumburg and Byck of the Albert Einstein College of Medicine, in a letter in the July 11 issue of the same journal, that other reported symptoms such as lacrimation, nausea, fasciculation, tachycardia, and syncope are attributable to anxiety and to fear of loss of face, which they designate as pseudopostsinocibaldefaciation, a splendid Teutonic term.

Schaumburg and Byck and others have estab-

lished the cause of the syndrome as monosodium glutamate (Accent or Ajinomoto), ingested by inherently susceptible persons in doses of 5 grams or more, an amount which may be present in a single portion of won ton soup. A dose of 25 grams has been found to produce no ill effects in persons who are not sensitive, according to four students at New York University School of Medicine.

There are many unanswered questions, such as whether this sensitivity is acquired, or genetically determined; but for the time being it might be wise for owners of Chinese restaurants to check on their chef's recipe for won ton soup and hot and sour soup, and see to it that they contain less than 5 grams of monosodium glutamate per portion. The second helping might well bear the label (which could be cut from a cigarette package) "Warning: Could be hazardous to your health."

The FTA-ABS: Best Test for Syphilis

The Fluorescent Treponemal Antibody Absorption (FTA-ABS) test is described elsewhere in this issue of the JOURNAL by Ralph Tanimoto, and compared with the currently standard Wassermann tests, the VDRL (Venereal Disease Research Laboratories) and RPCF (Reiter Protein Complement Fixation) reactions in their performance on 1,700 specimens.

No attempt was made to decide which tests were right (when they disagreed, that is) and which were wrong; the study merely compares their performance. There is so much evidence available already, however, to put the FTA-ABS test at the top of the heap for both sensitivity and specificity, that it is reasonably safe, in this kind of comparison, to assume that it is always correct.

If we make this assumption, then a negative VDRL test was in error in 81 specimens, and a

positive one was wrong in 335, out of 1,700 tests in which it was used.

The RPCF, known to be a more reliable test, was wrong on the negative side in 22 specimens, about one-fourth as many, and gave a false positive reading in 31, less than a tenth as many as the VDRL.

Statistically, this makes the VDRL a pretty poor test—very poor for diagnosis, and pretty poor even for screening; it seems to make the RPCF test, however, a pretty good one—1.5% false negatives, 1.8% false positives.

But is this good enough, in any individual patient? We don't think it is. One chance in 60 that a test for syphilis is wrongly positive—when you don't have to take that chance—is too big a risk. The right test to rely on is just the most reliable test available. And that test has been, since 1966, the FTA-ABS. Never settle for less!

Pooled Plasma May Be Pretty Safe

Though the Blood Bank of Hawaii has just started labelling pooled plasma with the same disclaimer of responsibility for transmission of hepatitis that they use on whole blood, the risk of this is still pretty remote.

Redeker et al reported last March¹ a 10 per cent incidence of hepatitis among 120 recipients of pooled plasma which had been stored at 30°C. for six months. Each pool contained plasma from 178 donors.

Blood Bank of Hawaii plasma is pooled from only 10 donors per pool, and is stored at 30°C. for over nine months—most of it, a full year—before use. In 14 years of use of such plasma, there has been only one solitary instance of suspected transmission of hepatitis, as compared to six or eight cases annually from use of whole blood.

The National Research Council appears to have overreacted somewhat to the Redeker report. They officially recommended that “the use of whole, pooled human plasma be discouraged and even discontinued unless a clear-cut case can be

made for its unique requirement.” The Division of Biologics Standards of the National Institutes of Health suggested that all licensed producers of plasma return their licenses.

The fact that Redeker's cases of hepatitis were mild and subclinical, and were discovered only by liver function studies and liver biopsies, does suggest that the reassuring experience of our own and other banks may be due to the mildness of such hepatitis rather than to its rarity.

And there is an acceptable alternative to its use: 5% serum albumin is available, and even the NIH believes it's safe from this standpoint.

Even so, the NIH's action reminds us of the old World War I story about the French farmer who complained that nude bathing in the river by American GI's was bad for his impressionable teenage daughters. The American CO pointed out that his farm was over a mile from the river. “But, Monsieur,” replied the farmer, “my daughters have a telescope.”

¹ Redeker, A. G., et al.: A controlled study of the safety of pooled plasma stored in the liquid state at 30-32 C. for six months: *Transfusion*, 8:2:57 (Mar.-Apr.) 1968. ■



Hawaii Academy of General Practice

In the last issue of the HAWAII MEDICAL JOURNAL, a challenge was posted: Do we, in organized medicine, take on the problem of providing good quality medical care to all of the people—not just to the affluent sector?

We had pointed out that our traditional system of free-choice-of-physician, private-practice-of-medicine type medical care is ideally suited to the economics of a competitive, free-enterprise society in which each competitor is presumed to be healthy, educated, and ambitious.

We need to devise something different, however, if the same good quality medical care is to be provided the poor, the illiterate, the nonrobust, and the hopeless in our midst.

President Rouse of the AMA put it succinctly when he called upon business, government, and the profession all to assist in a multiphasic effort to solve the problem. What planks shall we place in the profession's platform?

I. EDUCATION IN HEALTH, and continuing re-education, should be provided youngsters in school, as well as adults. Our people are woefully lacking in good medical common sense. Such a program of education in self-help and buddy-help could relieve the professional doctor and nurse of a large, unnecessary load.

II. A SYSTEM OF MEDICAL ECONOMICS in which the citizen carries a measure of financial responsibility, the government assisting but not taking over. Governor Nelson Rockefeller has said: "The greatest failing of publicly paid medicine, like Medicaid, is that it contains no self-restraining force to curb abuse and excessive expansion. The beneficiaries do not contribute financially, and therefore have no personal stake in the fiscal health of the system."

III. TRAINING PROGRAMS FOR PARAMEDICAL PERSONNEL can result in a wider application of good medical care under professional direction.

IV. SIMPLIFICATION AND REDUCTION OF PAPERWORK alone can permit existing numbers of physicians to care for many more patients and better. Current rules and regulations of our own making,

not to speak of those emanating from HEW, are producing a harassment of the practice of medicine.

V. PREVENTICARE—no major medical insurance program has yet come up with an incentive plan that will pay dividends if good health is maintained.

VI. A PROFESSIONAL TRAINING PROGRAM in which every medical school graduate (and nurse!), once he or she gets a degree, is assigned to a tour of duty in a "Medical Corps," serving either within or without this country's borders for one or two years, and then be released to seek specialty training in a hospital residency or elsewhere. This tour of "community service" could be extremely educational for the young physician in terms of his developing a knowledge of interpersonal relationships and the humanities; it would make a doctor of him. It would allow time for an evaluation of his bent—toward private practice, toward teaching, or toward research. It would provide a large pool of talent with which to staff health centers and outposts. It would give each physician a taste of salaried, no-free-choice type of medical practice without actually putting him into military service, although some might choose the latter. It would permit medical schools to continue the education of their graduates in an environment similar to the disappearing "teaching services." The medical schools would necessarily be involved in the "medical corps" thereby. It would provide the people who need it—the ones for whom quality medical care is now "out of reach" in terms of time, place, and cost—young, enthusiastic medical care under able direction of senior men. Instead of the government taking over the whole of medicine, as it seems bound to do under present programs, it can have this small part, sharing it with academe! The program would have to relinquish those that wanted out at the end of their tour of duty, to allow them to continue training and to enter into the private practice pool. ■

J. I. FREDERICK REPPUN, M.D.

This is the seventy-fourth installment of In Memoriam—Doctors of Hawaii:

Joseph Mark Sowers

Joseph Mark Sowers was born in Deer Creek, Illinois, on June 25, 1893. He lived with his family in Nebraska and eastern Washington before he attended and graduated from Lincoln High School in Seattle, Washington.



DR. SOWERS

After he got his degree from the University of Washington, he entered the Navy Medical Corps in February, 1918, and saw service in France. Following World War I, he entered Northwestern University Medical School where he graduated in 1924.

On completing his internship at St. Luke's Hospital in Chicago, he practiced medicine with Dr. Don Palmer in Seattle until he came to Hawaii to relieve Dr. Ray Mansfield at Waimea, Kauai. Later he relieved Dr. Chamberlain at Kula Sanatorium on Maui and then Dr. Njedloff and Dr. Lightner at Puunene, Maui. By this time he had decided he wanted to remain in Hawaii.

On October 25, 1930, Dr. Sowers married Margaret Venoss in Honolulu and went to Kauai as Medical Director of Samuel Mahelona Hospital. Two sons were born on Kauai: Joseph Mark Britton in 1932 and Samuel Russell Frederick in 1934.

In 1930 Dr. Sowers returned to Kula Sanatorium to be in charge of thoracic surgery. In November, 1938, he became ill and died at Paia Hospital on March 26, 1939, at the age of 45.

His family still lives on Maui. Joe, as everyone called him, was a very hard worker, but was always affable with a sunny disposition which everyone loved.

He was a member of Sigma Chi fraternity, Nu Sigma Nu medical fraternity, Kauai Masonic Lodge, Maui Post No. 8 of the American Legion and the Maui Country Club where he enjoyed golf on weekends.

Sidney Bourne Swift

Born in Ireland in 1847, Dr. Sidney Bourne Swift probably came to the United States about 1880. In 1881 he is listed as a veterinary surgeon in the Louisville, Kentucky, city directory. He continued to list himself thus until 1886, when the veterinary surgeon is dropped, and the designation physician follows his name, which gives rise to the speculation that perhaps he put himself through medical school working as a veterinarian. However, no record can be found as to which medical school granted his degree or when. We do know that in 1882 he became a naturalized American citizen.

The 1886 Louisville directory is the last one in which his name appears. When we next hear of him in March, 1888, he is ship's surgeon aboard the S.S. "Australia" and writing to the Hawaiian Board of Health requesting hospitalization at the Queen's Hospital for a member of the crew. On June 26, 1888, Dr. Swift arrived in Honolulu aboard the "Australia" accompanied by his wife, Louisa M., and their one-year-old son, Godwin B., to accept a position with the Board of Health. From July, 1888, to May, 1892, when he resigned, Dr. Swift was Government Physician for the Leprosy Settlement at Molokai. It was during his first year at Kalaupapa that Father Damien's death occurred, April 15, 1889, and it was Dr. Swift who took one of the few photographs of Father Damien just two days before he died. The doctor's work with the lepers brought him nothing but praise; and in his report for 1890 the President of the Board of Health writes of Dr. Swift, "the Board might search far and wide, and not find another physician who would fill the place he occupies so satisfactorily."

On June 30, 1892, Dr. and Mrs. Swift and son left on the S.S. "Alameda" for California. Just where he first located in that state is not known, but early in the 1900's he came to Marysville from Mendocino County. He is listed in the 1903-1904 Yuba County directory and ran the following ad in the same directory.

Dr. Sidney Bourne Swift
Odd Fellows Building, Marysville, Cal.
Formerly Resident Physician at Leper Settlement,
Molokai, H.I.
Surgery, Diseases of Women and Skin Diseases.
Fully Equipped to Meet Requirements of Modern
Methods.

continued page 60



University of Hawaii.....

The Section of Psychiatry has been granted \$23,887 annually by the National Institute of Mental Health for a period of five years. **Walter Char, M.D.**, Chief of Psychiatry, is principal investigator of the grant, which is for undergraduate training in psychiatry in the School of Medicine. The School of Nursing was recently notified of continuation of a \$29,532 annual grant for undergraduate training in psychiatric nursing.

Lawrence H. Piette, Ph.D., became Acting Chairman of the Department of Biochemistry and Biophysics on July 1, 1968, **Howard F. Mower, Ph.D.**, having left for a sabbatical year at the Technical University of Norway, Trondheim, Norway. The Mowers will have to live off something other than coconuts at Trondheim. **John B. Hall, Ph.D.**, **Robert H. McKay, Ph.D.**, and **Roy A. Scott, Ph.D.**, were promoted from Assistant Professor to Associate Professor. Dr. Hall is transferring to the Department of Microbiology and Dr. Scott, along with **Professor George A. Barber, Ph.D.**, is leaving for a new position at Ohio State University. **Professor Fred Greenwood, Ph.D.**, and his associate **Gillian Bryant, Ph.D.**, previously of the Imperial Cancer Institute of London, are establishing their laboratories in the Department of Biochemistry to study radioimmunoassay of hormones. **Professor Piette** was invited to present a lecture to the National Academy of Sciences' program on "New Physical Methods in Pharmacology," June 10, 1968.

Olaf K. Skinsnes, M.D., Professor of Pathology, presented a lecture, "Leprosy, a Model for Understanding Chronic Disease," at the AMA convention, San Francisco, June 22, 1968. **Ed Nishimura, M.D.**, attended the International Convocation on Immunology in Buffalo, N.Y., June 17-19, 1968.

In the Section of Surgery, **Chairman Richard Mamiya, M.D.**, is actively participating in the Regional Medical Program (Heart, Cancer, and Stroke), the aim of which is "to develop and maintain a region-wide capability whereby health personnel who render service to patients are provided expanded and varied opportunities to participate in continuing education in medical knowledge and technology and training in new methods of patient care." **Masato Hasegawa, M.D.**, is Program Coordinator of the RMP, **Robert H. Richart, Ph.D.**, is Chief of Staff Operations, **Lorraine String-**

fellow, M.P.H., R.N., is a Specialist in Nursing Education, **Faye V. Sargent, M.S.**, is a Health Systems Analyst, and **Jeanne U. Richart, R.N.**, is a Nursing Service Specialist. The RMP sponsored five nurses from Hawaii at an advanced course in coronary care at the Hospital of the Good Samaritan Medical Center, Los Angeles, June 26-28, 1968. Six RMP operational grant applications have been filed and site visits will be held this fall prior to their approval.

Mr. John McNeil began his duties as Assistant to **Dean Cutting** of the School of Medicine, on July 1, 1968. Mr. McNeil, formerly business manager for Annual Reviews, Inc., replaces **Harry Siegmund** as fiscal officer for the School of Medicine. **Windsor Cutting, M.D.**, Dean of the School of Medicine, attended the AMA Convention in San Francisco, the Board of Directors meeting for Annual Reviews at Boulder, Colorado, and the United States Adopted Names Council meeting in Chicago this Spring. During August he visited the Tropical Medical Center in Pago Pago, the Fiji Medical School in Suva, and the University of Auckland Medical School, and attended the Ichthyosarcotoxism (fish poisoning) Conference in Papeete, Tahiti.

E. Gene Ritter, Ph.D., Associate Professor of Speech Pathology and Audiology, was recently appointed by Governor Burns as one of the original seven members of the Hawaii State Board of Certification for Practicing Psychologists. The Board is charged with the duties of implementing the new State law regarding use of the title "Certified Psychologist," with certifying applicants, and with helping to insure better psychological services to the citizens of Hawaii.

The Department of Medicine has initiated a University of Hawaii Medical Service at St. Francis Hospital. A resident and an intern are continuously assigned to this service, and they have the primary responsibility, under the supervision of the faculty of the Department, for the care of patients assigned to the service.

In the School of Nursing, **Dean Marjorie Dunlap** and **Professor Marian Olson, Ph.D.**, Coordinator of Research, attended the American Nurses' Convention in Dallas in May. Dr. Olson was recommended by **President Hamilton** to appear in *Who's Who in American Education*, 1968

continued page 54

★Gynecologic Operations: Indications, Technic and Results

By Otto Kaser, M.D., and Franz A. Ikle, M.D., 377 pp., \$37.50, Grune & Stratton, 1967.

THIS ENGLISH LANGUAGE EDITION, from an original German publication, contains minor changes and omissions in the text, which do not detract from the original manuscript. Explicit, detailed, clear illustrations accompany all procedures. Indications, technical details, and results of procedures are fully explained.

Considerable space is allotted to the techniques of reparative surgery on the urinary and intestinal tracts. The author believes that anyone doing pelvic surgery should be thoroughly familiar with the normal anatomy and physiology of these systems, thus enabling one to correct such complications as can occur related to the pelvic surgery. Attention is also given to recent advances in more radical and complicated surgery for malignant disease. Radical vaginal hysterectomy is especially well described and illustrated.

This text is one of the most outstanding atlases of gynecological surgery.

SAMUEL J. BUIST, M.D.

Physiology of the Kidney and Body Fluids: An Introductory Text, 2d Ed.

By Robert F. Pitts, Ph.D., M.D., 266 pp., \$8.50, Year Book Publishers Inc., 1968.

THIS CONCISE, clearly written book provides a solid background in renal functions and a basis from which one can more fully appreciate the abnormalities associated with renal diseases. Because of the great amount of information contained, the book requires more thorough reading than a light skim. It is an excellent primer for the undergraduate student and a good review for practicing clinicians who are especially interested in renal problems.

IWAQ WILLIAM SHIRAKI, M.D.

Pediatric Therapy, 3rd Ed.

Edited by Harry C. Shirkey, B.S. (Pharm.) M.D., F.A.A.P., with 89 contributors, 1,294 pp., \$25.00 The C. V. Mosby Company, 1968.

THE LATEST REVISION of *Pediatric Therapy* is as excellent as Dr. Shirkey's two previous editions. This book has become a standard along with Nelson's *Pediatrics* and Kagan and Gellis's *Current Pediatric Therapy* for those who are involved in the care of children. Although most of the material is slanted toward therapeutic effects, precise diagnosis is stressed throughout. This follows Dr. Shirkey's dictum "diagnosis and treatment are wedded into a strong union." There are 114 chapters, seven brand new. These chapters encompass the complete field of pediatrics. Included in the book is an excellent section on adverse drug reactions, poisoning and its treatment, and a table of drugs which includes dosages, generic and trade names, contraindications, warnings, toxicity, etc. The presentation is excellent, being very concise but at the same time encompassing different views of therapy. The numerous photographs enhance the good material presented. In this age of drug-treatment-

★ means highly recommended.

oriented medicine, everyone should read the first 20 chapters in this book, which are related completely to the fundamentals of drug treatment and the adverse drug reactions. These chapters, mostly by Dr. Shirkey, show his tremendous knowledge and interest in the field of pharmacology.

As an added interest, especially for those who wish to support local products, Dr. Shirkey at the present time is Medical Director of Kauaikeolani Children's Hospital, here in Honolulu.

SORRELL H. WAXMAN, M.D.

Advanced Techniques of Hypnosis and Therapy: Selected Papers of Milton H. Erickson, M.D.

Edited by Jay Haley, 557 pp., \$14.75, Grune & Stratton, 1967.

MILTON H. ERICKSON has worked in the field of modern clinical hypnotism for over 30 years. He is generally acknowledged to be the world's leading practitioner of medical hypnosis. Twice a victim of poliomyelitis, he nevertheless practiced and worked (in Phoenix, Arizona) at a prodigious rate for many years. This 557-page text has a brief foreword by Dr. L. S. Kubie and a biographical introduction by Jay Haley.

The book is divided into three sections. The first has to do with techniques of trance induction, the second deals with experimentation with hypnosis, and the third section is entitled "Techniques of Therapy." There are some extraordinary clinical goings-on with patients in these latter papers, such as the indirect hypnotic therapy of an enuretic couple and the mother who was instructed to literally sit on her eight-year-old son for a period of several hours.

The book is well written and logically laid out, and large parts of it constitute fascinating reading. A useful index is included.

WILLIAM J. T. CODY, M.D.

Psychopathology of Mental Development

Edited by Joseph Zubin, Ph.D., and George A. Jervis, M.D., Ph.D., 658 pp., \$22.00, Grune & Stratton, 1967.

THIS VOLUME CONTAINS the proceedings of the 56th Annual Meeting of the American Psychopathological Association held in New York City February, 1966.

The text is divided into six parts, with an appendix. Part I covers genetics and neurophysiology and contains papers on chromosome studies, family studies in mental retardation, and biochemical factors in mental retardation. Part II includes sociocultural and paranatal factors, which is followed by a presidential address entitled "Intelligence, Biology and Social Responsibility," by Seymour S. Kety. I found Dr. Kety's paper quite interesting particularly where he emphasized Rosenzweig's data indicating that the normal morphological and biochemical development of the cortex depends upon its interaction with a world of sensory stimulation. For example he referred to the experiments of Riesen, who had one kitten learn a task by going through the paces involved while carrying, so to speak, another kitten on his back. The kitten that was carried through the proper movements but didn't perform them for himself never learned the task.

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Gilbert F. Sofio, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

INTERNAL MEDICINE

University of Illinois School of
Medicine—1946

Internship—Cook County

General Hospital—1946-1947

Residency—University of Maryland
Hospital—1947-1948

Newington V.A. Hospital—1950-1951

Gallinger Municipal (D.C. General)
—1952-1953



Eugene D. Rames, M.D.

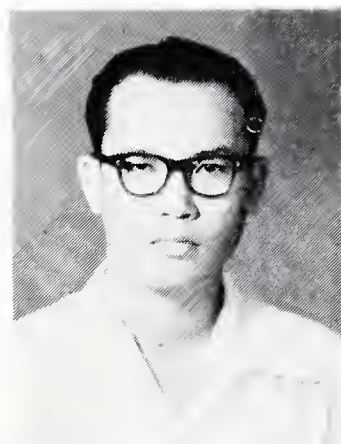
3420 Kuhio Highway
Lihue, Kauai 96766

INTERNAL MEDICINE

Harvard Medical School—1946

Internship—University of Minnesota
Hospital—1946-1947

Residency—V.A. Hospital,
Minneapolis, Minnesota—1950-1953



Katok A. Chuang, M.D.

3420 Kuhio Highway
Lihue, Kauai 96766

PEDIATRICS

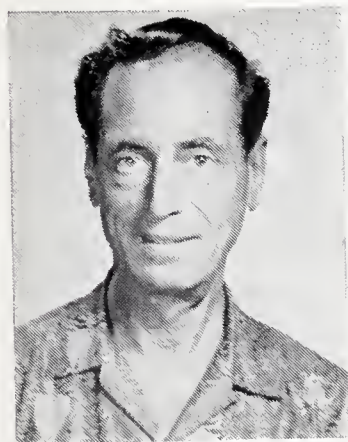
University of Santo Tomas—1957

Internship—Niagara Falls Memorial
Hospital—1958-1959

Residency—Presbyterian St. Luke's
Hospital—1959-1960

Kauikeolani Children's Hospital
—1960-1962

USPHS Fellow in Pediatric
Cardiology, UCLA—1962-1964



Jules B. Comroe, M.D.

404 Piikoi Street
Honolulu, Hawaii 96814

GENERAL PRACTICE

University of Chicago, Division of
Biological Sciences—1937

Internship—Los Angeles County

General Hospital—1936-1938

Residency—Los Angeles County
General Hospital—1938-1939



Leon B. Comroe, M.D.

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GENERAL PRACTICE

University of Chicago, Division of
Biological Sciences—1937

Internship—Los Angeles County

General Hospital—1936-1938

Residency—Los Angeles County
General Hospital—1938-1939

CLARENCE E. FRONK

1883-1968

After 84 years of a rich, full life, Dr. Clarence E. Fronk finally succumbed to the ravages of progressive cardiovascular and renal failure on February 17 of this year at U. S. Army Tripler General Hospital.

Within ten days of his demise, Senator Hiram L. Fong very admirably entered into the *Congressional Record* a fine two-column tribute to Dr. Fronk. The facts, figures, accomplishments, associations, and successes contained therein are truly a eulogy to a man who lived an extremely full life.

Senator Fong said:

"It is with deep sorrow that I pay tribute to the memory of an outstanding citizen of Hawaii who passed away recently. Death came to Dr. Clarence E. Fronk—Honolulu surgeon, chairman of the Honolulu Board of Parks and Recreation, and an internationally known horseman and big-game hunter—at the age of 84 on February 17 in Tripler Hospital in Honolulu.

"Dr. Fronk lived a full, vigorous and successful life. He combined a dedicated medical career with long years of civic and community service. He loved adventure and traveled far and wide as a true sportsman.

"Born March 30, 1883, in Conway, Iowa, he was graduated in 1906 from St. Louis University Medical School. After serving his internship, he was briefly in private practice in Missouri before being commissioned in the U. S. Army Medical Corps. He had the distinction of being the youngest division surgeon of World War I.

"Dr. Fronk resigned his Army commission in 1923 and began practicing medicine in Honolulu. In 1925, he became cofounder of the Fronk-Wynn Clinic, and, from 1934-56 was director of the Fronk Clinic.

"He was the physician for Oahu Prison for 10 years and an appraiser for probate courts. He retired from medical practice in 1956.

"His interest in big-game hunting began in the Philippines where he spent more than a year early in his Army career. In later years, he hunted also in Mexico, Indochina, Africa, India, and other areas.

"His more than 50 trophies—one of the finest big-game collections in the world—included tigers, lions, leopards, rhinoceros, buffalos, cheetahs, and many other animals.

"One of his favorites was a tiger he shot from 50 paces while hunting in central India in 1953 with Maharajah Yeshwat Roa of Indore.

"His other hobby was buying, selling, breeding, training, and riding show horses. He served as a director, vice president, and since 1959, regional director of the American Horse Shows Association. He was the fourth person to be made an honorary life member of the association.

"Dr. Fronk's medical affiliations included being a fellow of both the American College of Surgeons and the International College of Surgeons, and a member in the founder's group of the American Association for the Surgery of Trauma.

"He was a past president of the Hawaii State Medical Association, and a member of the American Medical Association, the Honolulu County Medical Society, and the National Association of Medical Directors of Life Insurance Co.

"He received campaign badges for service in the Philippines, Mexican border, World Wars I and II, Central Pacific Area, American Forces Reserve, and the Legion of Merit.

"He was in the U. S. Army Reserve from 1923 to 1946, when he retired with the rank of colonel. He was in active service from 1940 to 1944.

"He was a past president of the Reserve Officers Association, and a member of the Veterans of Foreign Wars and the American Legion.

"He was appointed to the Honolulu Board of Parks and Recreation in 1960, and became its chairman in 1964. He was chairman of the Hawaii Board of Industrial Schools from 1936 to 1940, and since 1944, served as a counselor for Aloha Council, Boy Scouts of America. He was on the board of managers of the Armed Services YMCA since 1951.

"Active in masonic affairs, he was a member of Lodge Le Progres de L'Oceanie No. 371 Free and Accepted Masons. As a 33d degree Mason, he was also a trustee and chairman of the Scottish rite bodies.

"He was a charter member and past president of the Adventurers Club of Honolulu, a member of the Explorers' Club of New York, and the Shikar-Safari Club of America. He was a past president of the Hawaii Fish and Game Association, and served several terms as president of the Hawaii Chapter, National Rifle Association.

"He is survived by his widow, the former Laura Mulhall, and two daughters, Mrs. Frederick (Elcanor) Bosman of Vancouver, B.C., and Mrs. Elton W. (Martha) Grenfell of Alexandria, Va.

"Hawaii has lost a most active, civic-minded, and distinguished citizen. His passing is mourned by the host of friends he made during his lifetime of service to his community and country.

"Mrs. Fong and I extend our heartfelt sympathy and sorrowful aloha to his beloved wife and family in their bereavement."

I should like to supplement this eulogy with the things that I remember concerning Dr. Fronk as to what he was rather than what he did. I knew Dr. Fronk for almost forty years as a man of stonewall courage, a man of better integrity. I knew him as one whose greatest driving force was a great love of people—a kindly, generous man. I never knew Dr. Fronk to complain of dismay, of depression, or even of fatigue in his lifetime. He was by all means the least procrastinating individual that I have known. Both duty and pleasure were always attacked with forthright immediacy. I believe his life was so full because he lived so vigorously in the present and not in the past. He had an unfailing sense of good humor and joshed frequently about his own faults as well as other matters. There was a man!

MARQUIS E. STEVENS, M.D.

Elected, Appointed, Honored

We learned that our venerable editor, **Harry Arnold, Jr.**, was one of 44 from Hawaii picked for the 35th edition of *Who's Who in America* and can think of no one more deserving of the honor. We congratulate **Diek Ando**, pediatrician and parliamentarian extraordinary, for his recent election as a delegate-at-large from the 15th District to Con Con. We are proud of **Fred Reppun**, father of seven, who was selected as the 1968 Father of the Year in the field of medicine. With characteristic aplomb, he had this sage advice to offer: "Most important is for a father and mother to be consistent and cohesive in their response to their children. Otherwise, insecurity develops."

The veterans of the 442nd Club and the D.A.V. in Hilo honored HMA President **Robert Miyamoto** with gifts and a "This is Your Life" skit. Bob trained with the 442nd during World War II and later served in Germany. We worried when he later entered the Queen's Medical Center for serious surgery and rejoiced when

the outcome was favorable. Entrepreneur **Edmund Lee** was elected Chairman of the Board of Royal State National Insurance Company of which he and **William Bergin** of Hilo were among the founders in 1961.

On the political front, we noticed that Governor Burns appointed **David Pang** to the Commission on Aging and **Patrick Cockett** of Lihue to the Board of Regents of the University. **Clarence Chang**, another regent, was recently elected vice chairman of the Board. (With the likes of Oliver Lee and the SDS students on the campus, the lot of a U. of H. regent is not an easy one.) Not to be outdone by the Governor, the Mayor appointed a **Stephenson, John**, and a **Stevenson, George**, to the Oahu Committee on Children and Youth.

During the 100th Anniversary of the Japanese immigration to Hawaii, the Japanese Government bestowed the Order of the Sacred Treasure, 6th Order of Merit to two local physicians, Hiloan **Zenko Matayoshi** and Honolulu **Yokichi Uychara**. The recently organized Sons of Italy elected **Roger Brault** a trustee. The East Manoa Lions elected **Clarence Sakai** 2d vice president. The Kailua Chamber of Commerce elected **James Mertz**

continued next page

ELDON R. DYKES, M.D.
1929-1968

"There are men, and classes of men," wrote Robert Louis Stevenson, speaking of the medical profession "who stand above the common herd." To know Eldon Dykes was to be reminded of this expression. He was a most remarkable physician and a remarkable man—a "man for all seasons," indeed.

He was born in Kingsport, Tennessee, July 9, 1929, one of seven children of a schoolteacher, and went to college and medical school at the University of Tennessee where he received his M.D. in 1952. After interning at Philadelphia General Hospital, he spent two years in the Army, during the Korean War.

He then took a residency in general surgery and then in plastic surgery at the Cleveland Clinic. He remained there on the permanent staff of the Department of Plastic Surgery for four years before accepting an invitation to establish a department of plastic, reconstructive, and maxillofacial surgery at Straub Clinic in Honolulu in 1963.

He had met and married Nancy Baierlein while in Philadelphia, and they have four children: Nancy and Carolyn, 14 and 10, and Brian and Scott, 8 and 7.

In Honolulu, his exceptional qualities of personality, character, and professional skill rapidly became apparent. As a surgeon, all problems engaged his closest attention and interest, from excision of minor benign skin lesions to the bilateral resection of an entire maxilla for what most surgeons would regard as inoperable carcinoma. He did all his own pre- and postoperative photography, and did it skillfully. He wrote a number of papers which were published in mainland medical journals and in the HAWAII MEDICAL JOURNAL; most recently, one on reconstruction of the thumb.

He brought the same careful, intelligent scru-

tiny to the problems of group practice that he brought to his surgical work, and the list of specific constructive suggestions he presented at his first interview with the Straub Clinic Executive Committee startled them more than a little.

At The Queen's Medical Center, his period of required supervision by a licensed surgeon was far from ended when his supervisor asked the chief operating room nurse if he could be excused from supervising Dr. Dykes' next operation. "Certainly," she snapped. "Anyone who does such beautiful surgery doesn't need to have anybody supervise him!"

Busy though he was, he had time for membership in the Honolulu Rotary Club and was manager of the Camp Branch of the Honolulu Y.M.C.A. He was also a deacon in Central Union Church, and an effective Secretary of the Straub Medical Research Institute for over two years.

It was in 1965 that Dr. Dykes discovered that he had a carcinoma of the cecum, and returned to Cleveland Clinic to have it resected by his friend and former associate, Rupert Turnbull. When liver metastases became evident over a year later, he went to New York where George Pack did a subtotal hepatectomy on him. Eighty per cent of his liver was removed. This he survived, with regeneration of nearly all of the removed liver tissue, and returned to full-time work. But it was too late, and despite a final battle with cobalt radiation and chemotherapy, he finally succumbed to his disease on July 31, 1968, only three weeks after his 39th birthday.

His loss is keenly felt, not only by his family, but by his friends and his professional associates. It is a blow to the whole community. He will be remembered with affection and respect.

HARRY L. ARNOLD, JR., M.D.

chairman of the Public Health Committee which will concentrate on the water pollution problem. The Hawaii Committee on Alcoholism elected **Robert Bell** to the executive committee and appointed as consultants **Anna Maria Brault, William Cody, Fred Dodge, Herman Kramer, Thomas Min, Robert Spencer, George Suzuki,** and **Garton Wall.**

The Gaylord Dillingham Memorial Chapter of the Military Order of World Wars elected **Ralph Cloward** surgeon and the Hawaii Chapter of the American Red Cross installed **Bob Peyton, Jr.,** as one of its directors. The Hawaii Heart Association presented **A. S. Hartwell** the annual service award for his work in founding the Association in 1968 and in establishing the Hawaii Cardiovascular Study in 1957. **John S. Hanley** received the award for distinguished service in cardiovascular medicine for his role in establishing the cardiopulmonary resuscitation center at Queen's and **Bertram Weeks** of Maui received the meritorious service award for his efforts in establishing the pulmonary care unit at Maui Memorial Hospital. **Ed Chesne, Niall Scully,** and **Yone-michi Miyashiro** of Kauai also received awards.

The Oahu Unit, Hawaii Division, American Cancer Society, elected **Clifford Strachley** vice president. The Hawaii Society of Internal Medicine elected **Ray deHay** president, **Charley Ching** vice president, and **Noboru Oishi** secretary-treasurer. **Richard K. C. Lee,** Dean of the School of Public Health, was appointed to active temporary duty for the summer with the Bureau of Health Manpower, National Institutes of Health, where he will assist in an assessment program of various health training grants.

Personal Glimpses . . .

We happened on the following bit of hospital corridor repartee: Internist **Ed Yamada** was saying, "A surgeon is like an archeologist. He has to dig gently to uncover a find." He also added, "A neurologist is like an electrician fixing the wires." We piped in: "An orthopedist is like a carpenter." ENT surgeon **Hideo Oshiro** was aroused: "Most internists are so afraid of a little knife." Ed retorted, "We get satisfaction by making careful and accurate diagnoses and saving the patients from the surgeon's blade. . . ."

A 58-year-old Caucasian woman with the rare Schmidt's Syndrome (Addison's disease with hypothyroidism) was first seen by a cardiologist who placed her on thyroid for her debilitating fatigue. She improved initially and then relapsed, so she was referred to endocrinologist **Ralph Beddow** who complimented the referring cardiologist by saying, "Fortunately we are all practicing internists even though we have our own subspecialties." During the ensuing discussion, Ralph described the Addisonian crisis precipitated by the Water Tolerance Test in which she drank 1,500 cc of water in the prescribed 10 minutes. **Bob Faus** observed that it was critical how the water was consumed. "A person drinking a six-pack of beer with a shot glass will become sick, but when drinking directly from the bottle will not." We hasten to opine that many of us would get sick even when drinking a six-pack directly from the bottles. . . .

Fred Dodge, fresh from a two-week Kona vacation during which he actually caught a 180-lb. *ahi* and a 20-lb. *aku,* proudly sported an unshaven face which made him look like B. O. Plenty. Several days later, he had shaved his chin and trimmed the mustache and we felt he looked like either Albert Schweitzer or Andy Gump, but Fred himself felt that he looked like Dr. Zhivago.

After seeing Fred's new look, **Ted Tseu** went on vacation and returned with a heavy beard which made him look every bit like Toshi Togo in the Goldfinger movie. Instead of knocking his opponents down with a steel bowler, Ted would cower his tennis opponents with a ferocious look and ram tennis balls down their throats.

Our favorite humorist and RMP director, **Masato Hasegawa,** was describing his reception on Kauai. "When

I went to Lihue, people thought I was blowing a lot of hot air again. . . . But this time I am sincere. . . ." After a moment's pause while he reflected on his own words, he qualified himself by adding, "Of course, I always have been sincere, you know. . . ." In describing his role as RMP director, he commented, "The only thing they stipulated was that I act prudently. . . . And I am acting prudently now. . . ."

Sure cure. . . . Bloodletting?

Sportsmen

In the sports world, **Richard You** figures prominently as usual. He was elected to the Helms Hall of Fame for weight lifting and was honored for developing champion weight lifters and for enhancing the game in Hawaii and on the mainland. Richard is current National Vice Chairman of the AAU Weight Lifting Committee and Secretary of the U.S. Weight Lifting Committee.

Richard is also John Santos' fight manager. We took these excerpts from *Star-Bulletin* sports editor Jim Heckmen's column on "A Day with John Santos": "By now it was after 10 o'clock. Time for a visit to Dr. Richard You, physical culturist, who is also John Santos' fight manager. Fight or not, Santos has to have his daily ration of shots. . . . 'One's B complex vitamins and the other for circulation,' Dr. You said as he made the injections. . . . 'Some things the body doesn't store and have to be replaced. John's in chemical balance now and ready to go. . . . ' Later that night, John was cool and methodical, as emotionless inside the ring as well as outside. . . . as economical with his punches as he is with his words. . . . Forty minutes after the opening bell, his hand was raised in victory."

Hal Wood, *Advertiser* Sports Editor, however, is not so sympathetic. "Dr. Richard You, who has never lost a fight, writes again an enlightening bit of note. 'We are developing a new Johnny Santos with a jet engine and atomic punch!' says Dr. You, one of our great fiction writers of our times. 'He is in good physical and mental condition, packing dynamite in either hand. All his weak points, especially his jaw are being corrected with proper diet and exercises.'" We suspect that all this is a promotional gimmick for Hal also writes: "Now this department gets an estimated 237,428 letters a year from Dr. Richard You. He usually tells how John Santos is going to knock out his foe, a prediction which comes true on rare occasions, and they always include a copy of a speech by Representative Spark Matsunaga to the U. S. House of Representatives made on November 8, 1965 extolling the virtues of Dr. Richard You and his XDR system of training."

In this day of aerobatics and jogging, we see this item in Lois Taylor's social column: "Jogging is like boiled spinach. Its marvelous for you. It isn't hard to take, but it is awfully boring. Because of this, the most faithful joggers believe in togetherness." She mentions Ulumaika Park in Waialae Kahala where **Dick Lam** and **Clifford Druecker** are two of the most faithful joggers. Dick apparently has his wife Lani jogging with him at 5:30 A.M. and that's even greater news.

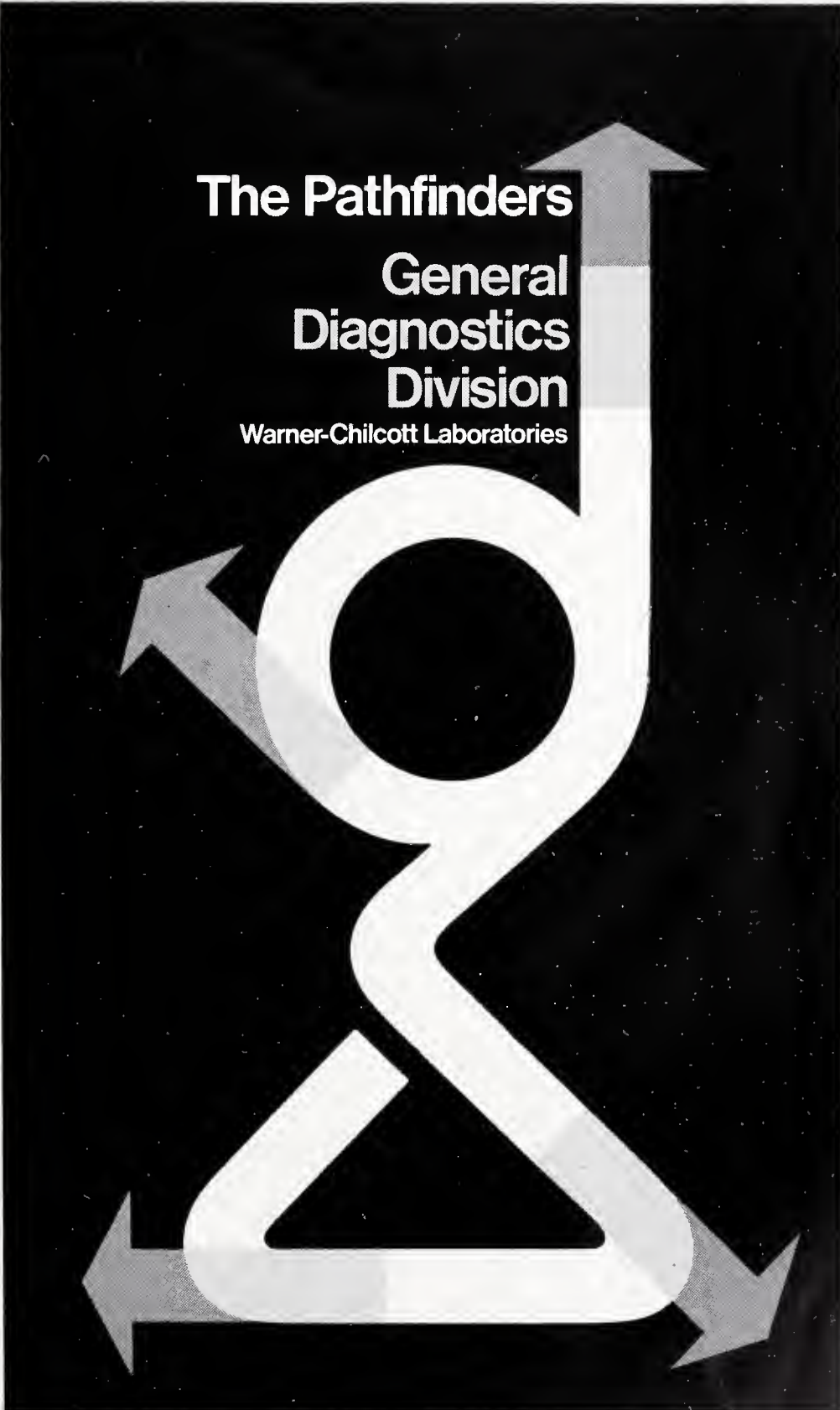
Fishing: **Jim Cherry,** fishing from the "Kaimalama-lama," landed a dinky little 28-pound marlin on light tackle while fishing on the Banks. **Art Sprague** was fishing off Lanai in April when the boat encountered a school of *mahimahi*. In the midst of all the fishing, Art's eight-year-old daughter fell into the middle of the *mahimahi* school. Art went in after her and since both could swim, there was no problem keeping afloat until the boat came back, but Art admitted that all he could think about was keeping their feet and legs as near the surface as possible because of the usual presence of sharks under such a school of fish. **Tom Frissell** and son Possum went on a three-day expedition to Molokai waters on "Maysie," which unloaded a wide assortment of fish. **Harold Sexton** won the *ono* division of the Annual

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The Pathfinders

**General
Diagnostics
Division**

Warner-Chilcott Laboratories



HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: EDITH G. EKSTEIN, MT(ASCP), U. S. Army Tripler General Hospital

Job Placement

This year Mary Nuha is keeping track of positions and position-hunters. If your laboratory has an opening for a medical technologist, or if you know someone who is looking for a job, inform Mary at the address below. And remember to let Mary know if the situation changes so that she can keep her lists current.

MARY NUHA, MT(ASCP)
Chairman, Job Placement Committee
1325 Center Street
Honolulu, Hawaii 96816
Telephone 770-512

Announcement

A spring semester, three-credit course, "Fundamentals in Immunology"—Micro 461—will be offered by the University of Hawaii. The course will start January 6, 1969, and end on March 14.

President's Message

The 36th Annual Convention of The American Society of Medical Technologists at the Shamrock Hotel in Houston, Texas, was cited as the "greatest" by over 3,000 ASMT members, friends, guests, and exhibitors. The theme of the convention, Reflect + Response = Results, was carried through in fine style.

It was an exciting experience to attend my first national meeting. Three things were especially impressive: (1) the clearly visible enthusiasm demonstrated by the members of our national society; (2) the substance and impact of the Key-note Address, "The Identity Crisis for an Emerging Profession," by Richard I. Evans, Ph.D., Professor of Psychology, University of Houston; and (3) the tremendous interest in the field of laboratory medicine as evidenced by over 150 excellent exhibitions by medical and scientific firms.

Since his message was so vitally important to the future of our Society I will relate to you, in some detail, significant points stressed by Dr. Evans.

In order to survive and profit from "The Identity Crisis for an Emerging Profession" Dr. Evans stated emphatically that an important change must first take place in our own thinking and in our attitudes toward our own profession before we can undertake to challenge several obstacles

which will offer great resistance. The first obstacle, in existence for many years, comes from the medical profession and has political, economic, social, and historical bases. However, the speaker expressed the optimistic view that since the associated subgroups in medicine are, themselves, re-vamping their organizational structures, they might become more receptive to the idea of acceptance of a professional identity for Medical Technologists with the ultimate development of more satisfactory working conditions than exist today. Yet, the greatest challenge resides among the prerogatives of the Medical Technologists themselves. According to Dr. Evans, we have a group which he labels "localites," who are complacent, content, and secure in the status quo. And then we have the "apathetic," or middle group, who will not attempt to do anything or accept any changes. They like to say, "What good will it do me?" This group is characterized by selfishness and unprogressiveness.

Fortunately, we also have the eager and progressive, but small, group of Medical Technologists who are flexible in their thinking and responsive to the needs of their community. These "cosmopolites" will have their influence felt by the entire organization while they are developing the professional image we need so much. Dr. Evans emphasized the need to convert more "localites" and "apathetics" to the ranks of the "cosmopolites" in order to destroy the dangerous misconception that we can emerge as an important profession by mere wishful thinking and apathy.

Why is this identity crisis so important and so much a part of our growth of stature? Only after we achieve the identity of a profession with the general public, only after we are accepted as such by other segments of the medical profession, can we move freely and independently, with pride, to accept the challenges of today and the future and offer our community the best possible care in the field of laboratory medicine. This identity must be secured as expeditiously as possible for the good of ourselves, our society, and the public.

The Keynote Address was only the beginning of an activities-packed meeting. Its echo, here, is my message for this issue. A real growth in membership is, I think, the key to our future—the first step in the establishment of an identity.

Hawaii's other delegates, Mrs. Louise Wulff and Miss Mary Connor, both contributed significantly to the success of the convention and I believe they

enjoyed it as much as I. Next year, ASMT's 37th, will be in Philadelphia.

My thanks to the Hawaii Society for being able to represent HSMT at Houston.

JAMES R. YANO, MT(ASCP)
President

Convention Report*

Texas, where there's more rivers and less water, more cows and less milk, more land and less people. We used to tease our Texan friends with that old saw, but that was before Houston, 1968! Flying over a country diminishes the size of the land and at 30,000 feet the rivers can be wet or dry, and so what most of Texas is like I wouldn't know. But Houston! It's a big, bustling city with small town undertones, beautiful buildings, lush greenery, good food, hospitable people, and a great place to have a convention.

The tone (and I use the word advisedly) of the whole meeting was set at the keynote session the first Monday morning when the delegates were treated to an hour of pop music by the Houston Symphony Orchestra. The Jesse H. Jones Hall for the Performing Arts, where the opening session was held, is an outstanding example of modern, functional architecture and it was a privilege to see it and to listen in it.

REFERENCE COMMITTEE. ASMT originated these committees three years ago and many heated discussions have taken place during their sessions. They were not very exciting this year, partly because most of the debatable issues relating to the Bylaws had been resolved in the last two years of these meetings and partly because groups presenting the material to the Reference Committees had organized and researched their subjects so carefully. I served on Reference Committee No. 4, Future Plans, Policies and Membership Services. Since the motions and recommendations referred to this committee have a direct bearing on HSMT activities as well as those of ASMT, a resumé of its actions is presented here.

In the near future you may expect to see: (1) A clearing house where societies preparing handbooks may obtain copies of some already in existence. (2) A new position of Education Director established and staffed in ASMT. (3) An invitational conference to include such organizations as American Association of Blood Banks, American Association of Clinical Chemists, American Society of Microbiologists, and the U.S. Dept. of Health, Education and Welfare to consider state and federal legislation as it applies to licensure of laboratory personnel and unionization affecting laboratory workers.

The committee also moved, and the House passed, motions approving: (1) The job descrip-

tion for Medical Technologists as defined in May, 1968, Standards and Studies. (2) That no amendments to ASMT Bylaws be considered for three years following the adoption of the Bylaws revision. (3) That the ASMT representation to the Board of Registry be instructed to investigate the use of continuing education as a condition for renewal of Registry certification. The last motion created some anxiety until it was made clear that the possibility of such a condition for renewal is only to be investigated.

BYLAWS REVISION. Revision was necessitated by the Society's application for incorporation. Every member of ASMT was mailed a copy of the proposed revision prior to the convention and each delegate was given another copy so that the document could be well studied. Again Miss Ruth Hovde and her committee did such an outstanding job that there were no major changes made from the floor of the House. Since you all have copies, there is no need to review the material here. According to ASMT General Counsel, Mr. John Sembower, ASMT has an outstanding set of Bylaws, written explicitly and with an economy of words—no government-type gobbledegook—which with ASMT's permission he will use as an example for several other organizations he is affiliated with.

REGIONAL ORGANIZATION. It was with something of a shock that we realized the plan for regional organization was a reality. Hawaii, a part of Region 10, is grouped with California, Arizona, and Nevada. The Hawaii delegation met with Nevada and Arizona delegates to discuss plans for possible joint meetings, newsletters, and representation on the national Board of Directors. The discussions will be more fully reported in the near future in the forthcoming newsletter. Arizona has a relatively active organization of about 100 members; the Nevada Society is very small and inactive. California, the other member in our region, has two state societies and a very large membership. There were no representatives from California at our group meeting. The other delegations would like to have a regional meeting in Hawaii if they could finance the air fare.

WORKSHOPS AND SEMINARS. I attended two workshops and a publications seminar. The seminar was both practical and interesting. Prize-winning journals were examined and the advantages of newsletters and mailed-out publicity were considered. General feeling was that a well-prepared bulletin is a fine image-maker but many state journals were criticized as being too newsletterish. It was pointed out that the two national publications, the *ASMT Journal* and the *Registry Bulletin*, contain the requisite scientific articles.

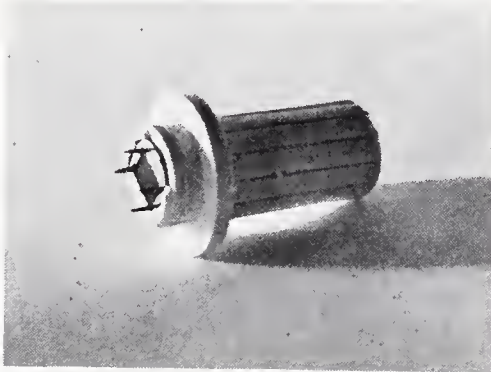
SOCIAL EVENTS. The Texans entertained us well. Ask Jim Yano and Mary Connor about the ball games! Social events were lovelier than ever. ■

LOUISE WULFF, MT(ASCP)
Delegate

* Hawaii delegates to the 36th Annual ASMT Convention, 1968, were Mr. James Yano, Miss Mary Connor, and Mrs. Louise Wulff. Some of the highlights are reported here.

To fight TB- find it first!

Make tuberculin testing routine
with every physical examination.



TUBERCULIN, TINE TEST

(Rosenthal)

Side effects are possible but rare: vesiculation, ulceration, or necrosis at test site. Contraindications: none, but use with caution in active tuberculosis. Available in 5's and 25's.



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University of Hawaii continued from 45

edition. A semester-long course "Current Practices in Nursing" was given this spring by U.H. instructors **Zane Ivey**, **Velda Kuykendall**, and **Donna Westow**. **Dean Dunlap** presented certificates to the graduates of this first course to be offered on a neighbor island. Three members of the nursing faculty, **Jacqueline Johnson**, **Zane Ivey**, and **Yukie Gross**, attended a workshop "Man and His Environment" on Kauai May 8-11, 1968. Three Professional Nursing faculty members, **Hazel Kim**, **Zane Ivey**, and **Ruth Iwata**, attended Curriculum Improvement Project meetings of the Western Council on Higher Education for Nursing in San Diego, and in Portland in June. **Dr. May Patterson**, Associate Professor of Professional Nursing, attended a Research Conference of the Nursing Council, Western Interstate Commission for Higher Education May 1-3, and also the Council for Institutional Research of the American Education Research Association May 6-8, 1968, in San Francisco. It would seem that our School of Nursing isn't missing any important meetings.

Mrs. Corrine H. Lee, Acting Chairman of the Department of Dental Hygiene during **Chairman Yoshi Koga's** sabbatical leave, was given the

continued page 56

things go
better
with
Coke



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Tareyton's charcoal filter
on your cigarette, you'd have
a better cigarette.**

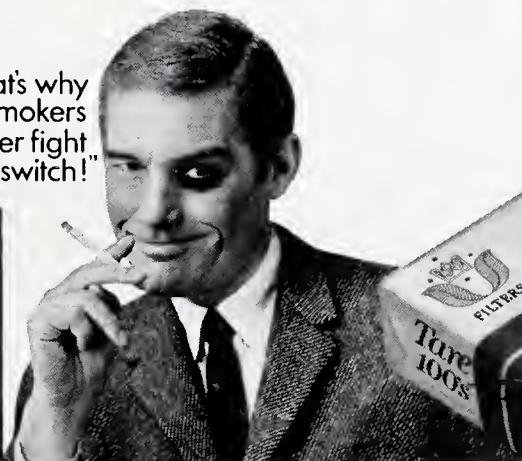


But not as good as a Tareyton.

"That's why
us Tareyton smokers
would rather fight
than switch!"



Activated
charcoal filter.



100's or king size.
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Your stationery
is a reflection
of you...
be certain
the reflection is good!

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the hallmark of fine printing in honolulu

University of Hawaii continued from 54

"Outstanding Service Award 1967-1968" of the Hawaii Dental Hygienists' Association. All of the University of Hawaii's dental hygiene students passed their National Boards, their class average being 91.7%. Dental Hygiene has been granted \$11,003.00 for the second year of a training grant under the Allied Health Personnel Training Act.

The Section of Obstetrics-Gynecology has a new Executive Committee, composed initially of the existing Joint Residency Training Committee of Queen's, Kapiolani, and St. Francis Hospitals. The current and immediate past Chief of Ob-Gyn of each hospital, plus an elected staff member from each, as well as the Director of Medical Education (John Krieger, M.D.) ex officio, will meet once a month to coordinate the teaching programs for first and second year medical students in the three hospitals. Robert W. Noyes, M.D., as Chief of the Section, will be Chairman of the eleven-man Executive Committee.

Vincent J. De Feo, Ph.D., and Milton Diamond, Ph.D., of the Department of Anatomy, and Charles Nugent, M.D., of the Department of Medicine, attended the International Congress of Endocrinology in Mexico City, July, 1968. ■



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\$1,000 1st prize winner,
Peter David Keaomalalama Yoshimi Malo
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Anxiety is an individual problem



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

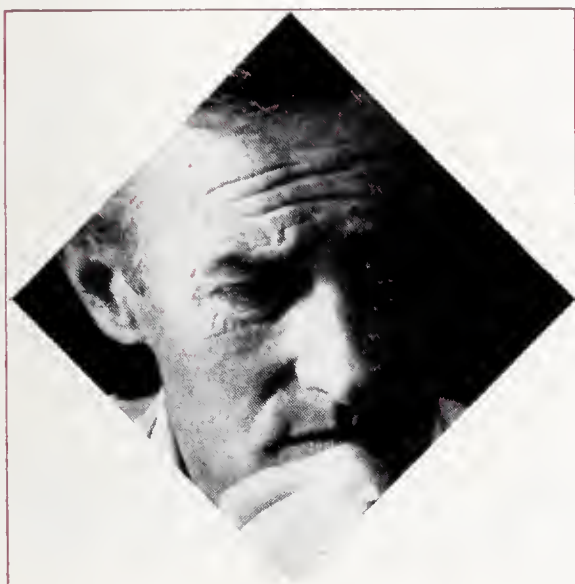
Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in

children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally ob-



**Because anxiety varies widely
from patient to patient . . .**

antianxiety Librium (chlordiazepoxide HCl) has been made available in several dosage strengths. Thus, Librium in doses of 20 or 25 mg t.i.d. is often effective in helping to control the more severe anxiety that may develop during periods of acute stress.

In lower doses of 5 or 10 mg three or four times daily, Librium helps alleviate symptoms of the more commonly seen mild to moderate anxiety. Also, mental acuity is generally preserved on proper maintenance dosage.

**for relief of
more severe anxiety**

Librium[®]
(chlordiazepoxide HCl)
25-mg capsules

when tablets are preferred

Libritabs[™]
(chlordiazepoxide)
25-mg tablets

served at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See **Precautions.**)

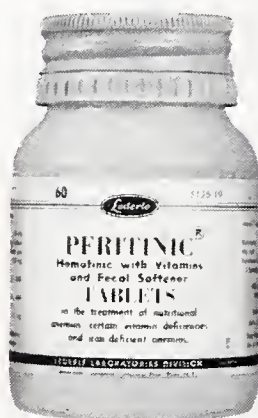
Supplied: Librium[®] (chlordiazepoxide HCl) *Capsules*, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs[™] (chlordiazepoxide) *Tablets*, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



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Bottles of 60



anticoptive, *adj.* (*anti* opposed to + *costive* causing constipation.)
Against constipation. Now isn't that a good idea in an iron-containing hematinic?



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Electricity in all its modalities. X Rays examinations, etc. etc.

In the August 14, 1904, issue of the *Marysville Daily Appeal* he ran a very similar ad except that he added midwifery and dropped skin diseases from his list. At one time he rented two rooms across the hall from his office which were furnished as an apartment for his wife, who was blind, enabling him to be near her. The doctor was the owner of considerable property in Marysville, including an apartment house which he built.

A resident of Marysville whose parents rented a house from Dr. Swift remembers him as something of an eccentric who always wore a silk top hat, never removing it even at the bedside of his patients. He also recalled that the doctor always had corned beef and cabbage for Sunday dinner, a practice of which his near neighbors could hardly remain unaware.

In March, 1912, Dr. Swift moved to Stockton, California, and opened an office. Sometime, probably early in 1914, he entered Clark's Sanatorium, a private mental hospital in Stockton. Here he died on March 8, 1914, at the age of 67.

He was a member of the Knights of Pythias, Aurora Lodge No. 51, of Ferndale, California, the Odd Fellows, the Yuba Lodge of Masons, and the Knights Templar in Louisville, Kentucky. ■



These glasses are important to him—in his work, socially, and in terms of his physical well-being.

When's the last time you had an eye check? Schedule an appointment soon with your eye physician.

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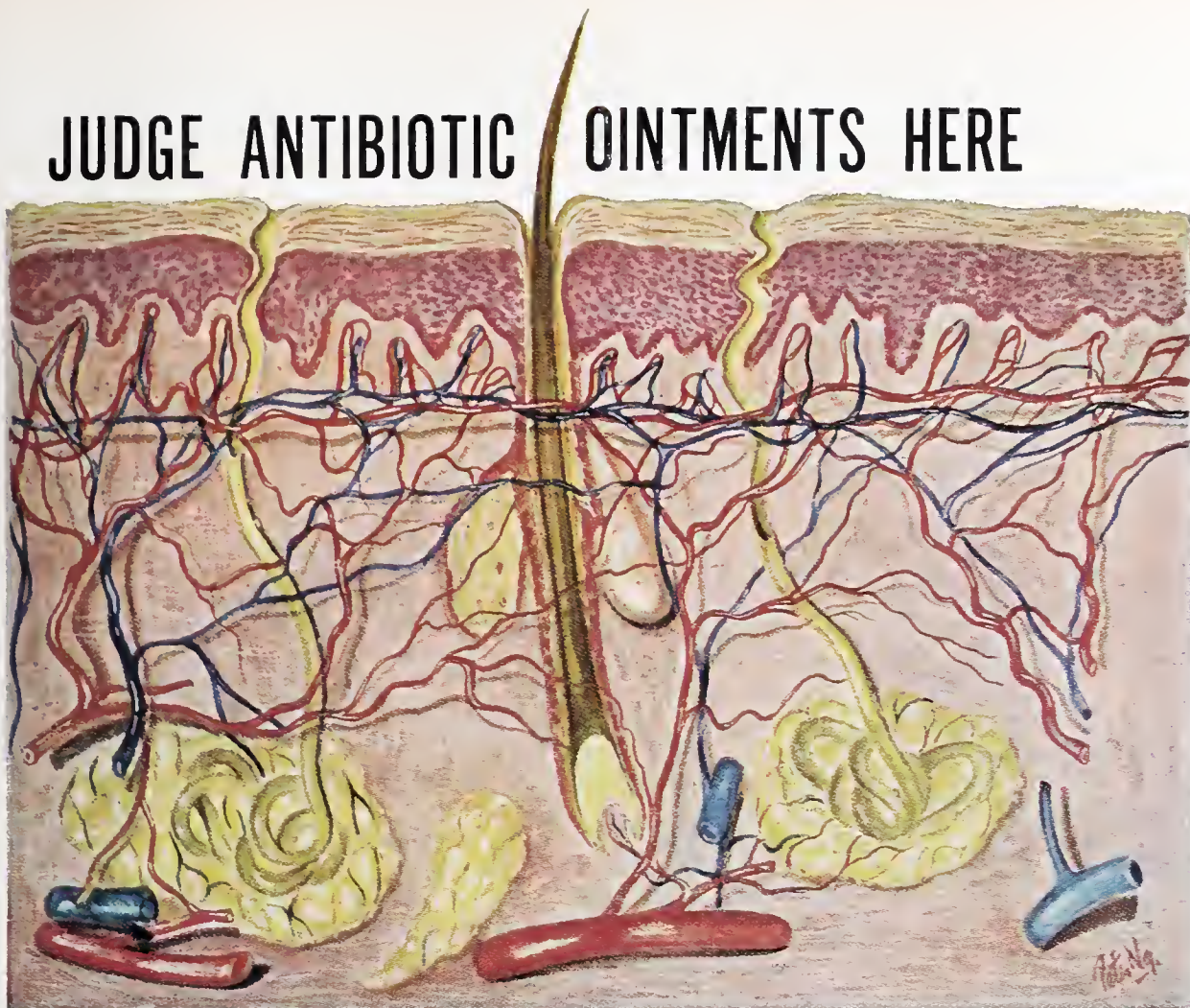
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Results on skin are final proof of any topical antibiotic's effectiveness

No in vitro test can duplicate a clinical situation on living skin. 'Neosporin' (polymyxin B — bacitracin — neomycin) Ointment has consistently proven its effectiveness in thousands of cases of bacterial skin infection. The spectra of the three antibiotics overlap in such a way as to provide bactericidal action against most pathogenic bacteria likely to be found topically. Diffusion of the antibiotics from the special petrolatum base is rapid since they are insoluble in the petrolatum, but readily soluble in tissue fluids. The Ointment is bland and nonirritating.

Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.
Complete literature available on request from Professional Services Dept. PML.

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Professional people are steering to Hawaii Leasing for attractive auto leasing arrangements. A new automobile, with radio, power steering and automatic transmission can be leased for as little as \$2.60 per day. No costly repair bills... the manufacturer's warranty is passed on to you. Earlier new car replacement — and many tax saving advantages. Call us. We have the figures to prove our point.



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Notes and News *continued from 50*

Heart Fund Benefit with a 26½-pounder. The annual benefit is staged by the Kaneohe Yacht Club and at the end of the tournament the fish is auctioned off on the docks. The amount raised for the heart fund this year was \$400. **Tom Richert** on the "Hula Kai" entered the Hawaii Big Game Fishing Club tournament and caught a 182-pound marlin off the north shores.

Visiting Physicians

In May, erudite **Charles Thompson**, Professor of Medicine at Hahnemann Medical College, spoke on "Determinants of Esophageal Pain" to a capacity crowd at a Friday morning Queen's medical conference. Also in May, we were happy to see a willowy and beaming **Charley Judd** at the HMA banquet when he flew up from Samoa to receive the annual Robins Community Service award. In his characteristically humble and sincere way, Charley thanked the Woman's Auxiliary for the medical supplies it has been sending to Samoa and received an enthusiastic standing ovation when presented the award. We were happy to learn that he may be returning to become a history of medicine professor at our local medical school. Also during the HMA meetings, **Gail Anderson**, Associate Professor of Obstetrics and Gynecology at the University of Southern California, spoke on the uses of estrogen-progestin preparations. We learned that the discovery of the Mexican yam's high production of diosgenin has made the low cost synthesis of these hormones possible. Gail recommends the use of hormone therapy for women during and after menopause.

continued page 66



Blessed event?

Not entirely, when nausea and vomiting occur in early pregnancy.

Emetrol offers prompt and safe relief. Local rather than systemic action provides emesis control on contact with the hyperactive G.I. tract.* In a study of 123 pregnant women, the drug produced measurable improvement in 79% of patients in controlling vomiting.¹

*As shown by *in vitro* studies.

1. Crunden, A. B., Jr., and Davis, W. A.: Am. J. Obst. & Gynec. 65:311 (Feb.) 1953.



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Even better together

Serpasil®-Esidrix®

#2 Tablets

(0.1 mg reserpine and 50 mg hydrochlorothiazide)

#1 Tablets

(0.1 mg reserpine and 25 mg hydrochlorothiazide)

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C I B A



Photo professionally posed.

No injection after all! This penicillin produces high, fast levels—orally.

Pen-Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN·VEE® K**
(potassium phenoxymethyl penicillin) 

ENDURON[®] ENDURONYL[®]

METHYCLOTHIAZIDE

Each tablet contains
Methyclothiazide 5 mg. with
Deserpidine 0.25 mg. or 0.5 mg.

Indications: Edema and mild to moderate hypertension (Enduron), and mild to moderately severe hypertension (Enduronyl). More potent agents, if added, can be given at reduced dosage.

Contraindications: Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease or impending hepatic coma (hepatic coma due to hypokalemia has been reported in patients on thiazides). Do not use Enduronyl in severe mental depression, suicidal tendencies, active peptic ulcer, or ulcerative colitis.

Warnings: Consider possible sensitivity where there is history of allergy or asthma. If added potassium is indicated, dietary supplementation is recommended. Reserve enteric-coated potassium tablets for cautious use only when necessary, as they may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation often requiring surgery; discontinue them immediately if abdominal pain, distention, nausea, vomiting, or g.i. bleeding occurs. Neither Enduron nor Enduronyl contains added potassium.

Precautions: Use thiazides cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery, thiazides may reduce response to vasopressors, and increase response to tubocurarine. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia) in all patients. In hypokalemia (especially in digitalized patients) give supplemental potassium. In hypochloremic alkalosis, give supplemental chloride.

Use rauwolfias with caution in patients with history of peptic ulcer. Rauwolfias with anesthetics may produce hypotension and bradycardia. Discontinue Enduronyl two weeks before elective surgery. Consider vagal blocking agents during emergency surgery. In epilepsy, adjust anticonvulsant dosage. In electroshock, shorten stimulus strength and duration. In occasional patients with depressive tendencies, rauwolfias may precipitate severe mental depression that usually disappears when drug is stopped.

Adverse Reactions: Thiazide reaction include blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, serum uric acid or blood sugar; anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice, symptomatic gout, and pancreatitis. Cutaneous vasculitis in the elderly has been reported with other thiazides. Adverse effects with deserpidine are qualitatively similar to those with reserpine, but their incidence is lower. These include nasal stuffiness, abdominal cramps or diarrhea, nausea, headache, weight gain, reduced libido and potency, peptic ulcer aggravation, epistaxis, skin eruption, asthma in susceptible patients, electrolyte imbalance, excessive salivation, and a reversible Parkinson's syndrome. Excessive drowsiness, fatigue, weakness, and nightmares may signal mental depression. Thrombocytopenia, purpura, and a symptom manifested by dull sensorium, deafness, uveitis, glaucoma, and optic atrophy are rare allergic reactions to other rauwolfias. Hypotension from antihypertensive agents may precipitate angina attacks in susceptible individuals. Usually adverse reactions disappear when drug is withdrawn.

EUTRON[™]

Each tablet contains
Pargyline Hydrochloride 25 mg.
with Methyclothiazide 5 mg.

Indications—Moderate to severe hypertension.

Contraindications—Pheochromocytoma, paranoid schizophrenia, hyperthyroidism and advanced renal failure. Not recommended in malignant hypertension, children under 12, pregnant patients.

Do not use with: centrally or peripherally acting sympathomimetic drugs; foods high in tyramine (e.g., aged and natural cheeses); parenteral reserpine or guanethidine; imipramine, amitriptyline, desipramine, nortriptyline or their analogues; other monoamine oxidase inhib-

itors; methyl dopa or dopamine; separate Eutron and these agents by two weeks.

Sensitivity to thiazides; severe renal disease (except nephrosis) or shutdown; severe hepatic disease; impending hepatic coma from thiazide-induced hypokalemia.

Warnings—Patients: 1. No other drugs (particularly "cold preparations" and antihistamines), cheese or alcohol without physician's consent. 2. Promptly report orthostatic symptoms, severe headache, other unusual symptoms. 3. Angina pectoris or coronary artery disease patients must not increase physical activity with improved anginal symptoms or well-being.

Physicians: 1. Use antihistamines, hypnotics, sedatives, tranquilizers and narcotics (meperidine contraindicated) cautiously in reduced doses. 2. Stop Eutron two or more weeks before elective surgery; in emergency surgery reduce premedication (narcotics, sedatives, analgesics, etc.) to 1/4 to 1/5; carefully adjust anesthetic dosage to patient response. 3. Use cautiously in advanced renal failure. 4. Pargyline may induce hypoglycemia. 5. Consider possible sensitivity reactions when a history of allergy or asthma is present. 6. If potassium is indicated, dietary supplement is recommended; enteric-coated potassium tablets may induce serious or fatal small bowel lesions (stenosis with or without ulceration), cause obstruction, hemorrhage, and perforation frequently requiring surgery; discontinue medication immediately if abdominal pain, distention, nausea, vomiting or gastrointestinal bleeding occurs; Eutron does not contain added potassium. 7. Possible systemic lupus erythematosus has been reported for thiazides.

Precautions—Pargyline: Use cautiously at reduced dosage; caffeine, alcohol, antihistamines, barbiturates, chloral hydrate, other hypnotics, sedatives, tranquilizers, narcotics. Periodically do urinalyses, blood counts, liver function tests, etc. Use with caution in liver disease. Watch for orthostatic hypotension, especially in impaired circulation (e.g., angina pectoris, coronary artery disease, cerebral arteriosclerosis); also, augmented hypotension in concomitant febrile illnesses. Reduce or discontinue if hypotension is severe. In impaired renal function watch for cumulative drug effects, elevated BUN and other evidence of progressive renal failure; withdraw drug if these persist. In surgery increased central depressant response (hypotension and increased sedative effect) can be controlled by (1) discontinuing at least two weeks prior; (2) in emergency surgery lowering dose of premedication; (3) when necessary, administering a vasopressor. Do not use in hyperactive and hyperexcitable patients. Pargyline may unmask severe psychotic symptoms where emotional problems pre-exist. Use cautiously in Parkinsonism, especially with antiparkinsonian agents. In prolonged therapy, examine for change in color perception, visual fields, fundi and visual acuity. Also, prolonged therapy has made certain patients refractory to nerve blocking effects of local anesthetics.

Methyclothiazide: Use cautiously in severe renal dysfunction, impaired hepatic function or progressive liver disease; also in pregnancy (bone marrow depression, thrombocytopenia, and altered carbohydrate metabolism have been reported in certain newborn). In surgery thiazide may reduce vasopressor response and increase tubocurarine response. Antihypertensive response may be enhanced following sympathectomy. Watch for electrolyte imbalance (e.g., hyponatremia). Give supplemental chloride if hypochloremic alkalosis occurs and supplemental potassium if hypokalemia occurs (especially in digitalized patients). Thiazides may decrease serum P.B.I. without signs of thyroid disturbance.

Adverse Reactions —Pargyline: Orthostatic hypotension and associated symptoms, mild constipation, fluid retention, edema, dry mouth, sweating, increased appetite, arthralgia, nausea, vomiting, headache, insomnia, difficulty in micturition, nightmares, impotence, delayed ejaculation, rash, purpura, weight gain, hyperexcitability, increased neuromuscular activity and other extrapyramidal symptoms. Drug fever is extremely rare. Reduction in blood sugar and hypoglycemic effects are possible. Congestive heart failure has been reported in a few patients with reduced cardiac reserve.

Methyclothiazide: Blood dyscrasias (thrombocytopenia with purpura, agranulocytosis, aplastic anemia); elevation of BUN, blood sugar or serum uric acid (gout may be induced); anorexia, nausea, vomiting, diarrhea, headache, dizziness, paresthesia, weakness, skin rash, photosensitivity, jaundice and pancreatitis. Cutaneous vasculitis in elderly patients has been reported with other thiazides.

If side effects are severe or persist, reduce dosage or withdraw drug.



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Notes and News continued from 62

We enjoyed Tomi Knaefler's interview of **Bernard Brodie**, NIH's Lasker Award winner for last year and one of our leading pharmacologists, who was here at the Med School on a sabbatical. It seems that Bernard was a high school dropout and a "late bloomer." He served in the voluntary Canadian Army until he decided to go to college. But then finances became a problem, so he decided that in the army, the only solution was to become an unbeatable poker player. He studied and mastered the theory and practice of poker and the laws of chance governing the turn of the cards. Ten months later he left the army with \$5,000 and entered McGill University. Tomi's summary of Bernard's character was pure idolatry: "This facility to be fluidly open-ended is possibly at the heart of Brodie's success. Peppered throughout his life is his refusal to accept what is just because it is, coupled with iron perseverance to pursue hunches with the spirit of the gambler and the logic of a mathematician."

Dedicated pediatrician and newly arrived Medical Director for Children's Hospital Harry Shirkey says: "A measure of the real cultural sophistication of a community is how well it looks after its children." "There is need for a children's treatment center which would coordinate all child health care and services, health education, and research." He also thinks big when he says: "I think it's important that we should be constantly aware of Hawaii's geographic location. We have a role to play in the Pan Pacific area. Medicine can break down many barriers."

Not to be outdone by the optometrists, our ophthalmologists invited **Arthur Keeney** of the Wills Eye Hospital and Research Institute in Philadelphia to discuss dyslexia (word blindness to the uninitiated), which may be hereditary or acquired and is caused by the brain's inability to interpret symbols. Fairly typical tip-offs we learned, are bizarre writing, figure and letter

reversals, incomprehensible spelling patterns, and gross inability to write on a straight line. Since conventional teaching techniques fail, Arthur pointed out, those affected should be picked out when they first begin school for with special exercises, constant drilling, and affection from therapists and parents, these youngsters can overcome this handicap.

Crusader **Louis Gluck**, head of the Special Care Unit for Infants at the Yale-New Haven Hospital, spoke on the advantages of special care units for a community's babies. He pointed out that there are about 140,000 "high risk" infants born in the U.S. every year and about 60,000 to 80,000 live. Instead of scattering the special services required all over a hospital as is the usual case, he advocates special care units in which all of the services, viz, surgical, medical, and intensive care nursing, are concentrated. By doing so, the mortality rate in New Haven has been reduced by 50 per cent.

We are grateful to **Paul Sanazaro**, Director of the National Center for Health Services Research and Development in Washington, D.C., for his many recommendations, especially in how we can assess and improve the quality of our professional performance, how our profession can improve community medical care and how and what type of basic studies can be pioneered here.

In August, an athletic looking professor of medicine with a pleasant European accent treated us to a simple, concise, yet all-inclusive lecture on the treatment of hypertension. **Francisco Del Greco**, Visiting Professor of Medicine at St. Francis Hospital, was born and educated in Italy, which he left in 1951, and is presently Professor of Medicine at Northwestern University Medical School. While here, he lectured on various aspects of kidney diseases, acute and chronic renal failure, hormonal control of water and electrolyte excretion, kidney transplants, glomerulonephritis, and other esoteric subjects which he managed to keep understandable, alive, and unadulterated with distracting jokes. Italy's brain drain has been America's brain gain.

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he was driving failed
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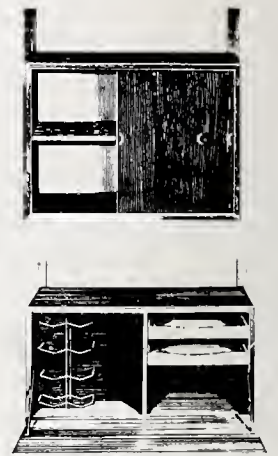
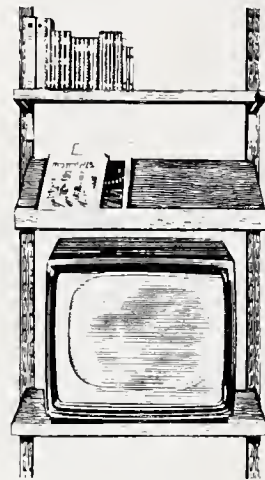
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Professional Moves

We must apologize for our usual tardiness and back-track to April lest we overlook someone. The surprise call-up in April of the Hawaii National Guard's 29th Brigade had a sobering effect on our complacent medical community. **Shigemi Sugiki**, Straub Clinic's sole ophthalmologist, had to pack up and leave a 40-patient-per-day clinic until a replacement could be found. The Medical Group's **Bob Nemechek** gave up his orthopedic practice to become battalion surgeon for the 487th Artillery Battery. While others had qualms about leaving civilian life, **Al Majoska**, our City-County Chief Medical Examiner, felt his Country needed him more than our City and County and volunteered for active duty as Brigade Surgeon. When the Army cut out its traditional red tape and complied with his request within a matter of weeks, Al was so surprised that he reported for duty in the wrong uniform. Also unpleasantly surprised was his deputy and part-time medical examiner, **Richard Wong**, who lamented: "I don't know what I'll do. I really haven't considered anything like this. Two years . . . ?" Carole Majoska was quite philosophical as she said: "I'm quite proud of the fact that he is doing what he's doing. If the Country needs him, I'm quite prepared to accept the disruption of our lives."

Also in April, otolaryngologist **Arthur Young** opened his practice at 181 So. Kukui and the Anesthesia Associates comprised of **Luke Tajima**, **Edwin Ichiriu**, **Naomitsu Tajima**, and **Mitsuo Hattori** and experiencing growing pains, relocated to larger quarters at 1741 Nuuanu Avenue. In May, former Waialua Plantation physician **Rodman Miller** moved to new quarters at 66-230 Kam Hwy. in Haleiwa. Also in May, surgeon **Henry Oyama** joined the Central Medical Clinic when **Dick**

continued page 73



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Mamiya left to become Professor of Surgery of the U. of H. Med. School and relocated at 252 Harkness Hall, Queen's Medical Center. We also found internist **Roger Ogata** affiliating with the Medical Group and recently wed **Murray Berger** opening a Hawaii Kai branch office. In June, pediatrician **Duke Choy** moved from Kaimuki to the Windward Medical Center in Kailua, ophthalmologist **James Johnston** opened at 45 Aulike St., also in Kailua, and **Dennis Fu**, recently discharged after two years of practicing pediatrics on military dependents at Fort Carlson, Colorado, decided against resuming his practice in Honolulu and joined the Maui Medical Group in Lahaina.

Going into July, **Kiyoshi Inouye**, forced to relocate when the City purchased his choice property at King and Kapiolani, moved to 1026 So. King. Otolaryngologist **Walter Yokoyama**, **Toru Nishigaya's** son-in-law, joined **Hideo Oshiro** in the Medical Arts Bldg., another ophthalmologist **Malcolm Ing** associated with **Harold Moffat** and **Gerald Faulkner** at 1441 Kapiolani Blvd., a **Helen Sylvia Perey** joined the Maui Medical Group, and **Allan Young**, back from three years of allergy training, resumed his practice at the King Center Bldg. where **Emiko Sakurai** has been holding the fort. In August, thoracic surgeon **Nathaniel Ching** opened at 203 So. Vineyard, internist **Philip Foti** associated with **Mor McCarthy** at the Kailua Professional Center, and yet another otolaryngologist, **Lester Bergeron**, joined the Fronk Clinic. Internist **Myron Shirasu** received a personal letter from the President and is leaving the Central Medical Clinic to report to Fort Sam Houston by September 18 for orientation; he will be stationed at Camp Zama, Japan. Myron, we notice, is taking his draft notice

continued page 74

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Notes and News continued from 73

quite well, but then being single and footloose may explain his apparent unconcern.

We were happy to learn that **Ralph Platou's** replacement as Children's Hospital Medical Director is yet another renowned pediatrician, **Harry Shirkey**, whom we remember as a visiting professor in 1966. Harry was Medical Director of the Birmingham Children's Hospital, Professor and Chairman of the Department of Pharmacology at Sanford University and Director of Pediatric Pharmacology at Alabama Medical College. He is well known for his papers on pediatric drug use, and will be chairman of the Department of Pediatrics and Professor of Pediatrics and Pharmacology at the U. of H. Medical School as well.

Aldon Roat, who has been chief of the preventive and clinical services branch of the State Health Department's Mental Health Division, replaced **Hubert Zappas**, the acting administrator of the Hawaii State Hospital. Hubert is returning to private practice in California while Aldon, we learned, was in private practice in Beverly Hills, Calif., before coming here. But then, perhaps all that glitters is not necessarily gold. ■

Book Reviews continued from 46

Part III is Epidemiology and includes a paper in which one of the co-authors is Dr. Ralph V. Platou (whose name is misspelled "Paltou" throughout). Dr. Platou's paper is entitled Genetics and Microcephaly in Louisiana.

The remaining three parts are entitled Behavior Characteristics and Learning, Observational Techniques and

Measurement of Intelligence, and Diagnosis and Rehabilitation. Despite the clinical sound of the last part, it as well as the book as a whole, is one which is essentially of more interest to research psychologists and laboratory investigators rather than to active clinicians.

In the appendix there is a list of the membership of the American Psychopathological Association, which totals only about 200 members, one of whom is Dr. Richard D. Kepner of Honolulu. He and his fellow members constitute a distinguished group.

WILLIAM J. T. CODY, M.D.

Also Received

The Care of the Geriatric Patient

Edited by E. V. Cowdry, Ph.D., Sc.D. (Hon.), 430 pp., \$15.75, C. V. Mosby Co. 1968.

A MULTIDISCIPLINARY APPROACH to the geriatric patient. This comprehensive text is highly recommended for the clinician interested in this important segment of medical practice.

The Country Doctor and the Specialist

By Fred Lyman Adair, M.D., 215 pp., \$6.75, Adair Award Fund, Box 65, Maitland, Florida 32751, 1968.

AN AUTOBIOGRAPHY OF ONE OF THE outstanding pioneers in obstetrics and gynecology. This paperback recording of medical history should interest those concerned with the care of the mother and child. The book is given free with each \$10.00 contribution to the Adair Fund. ■

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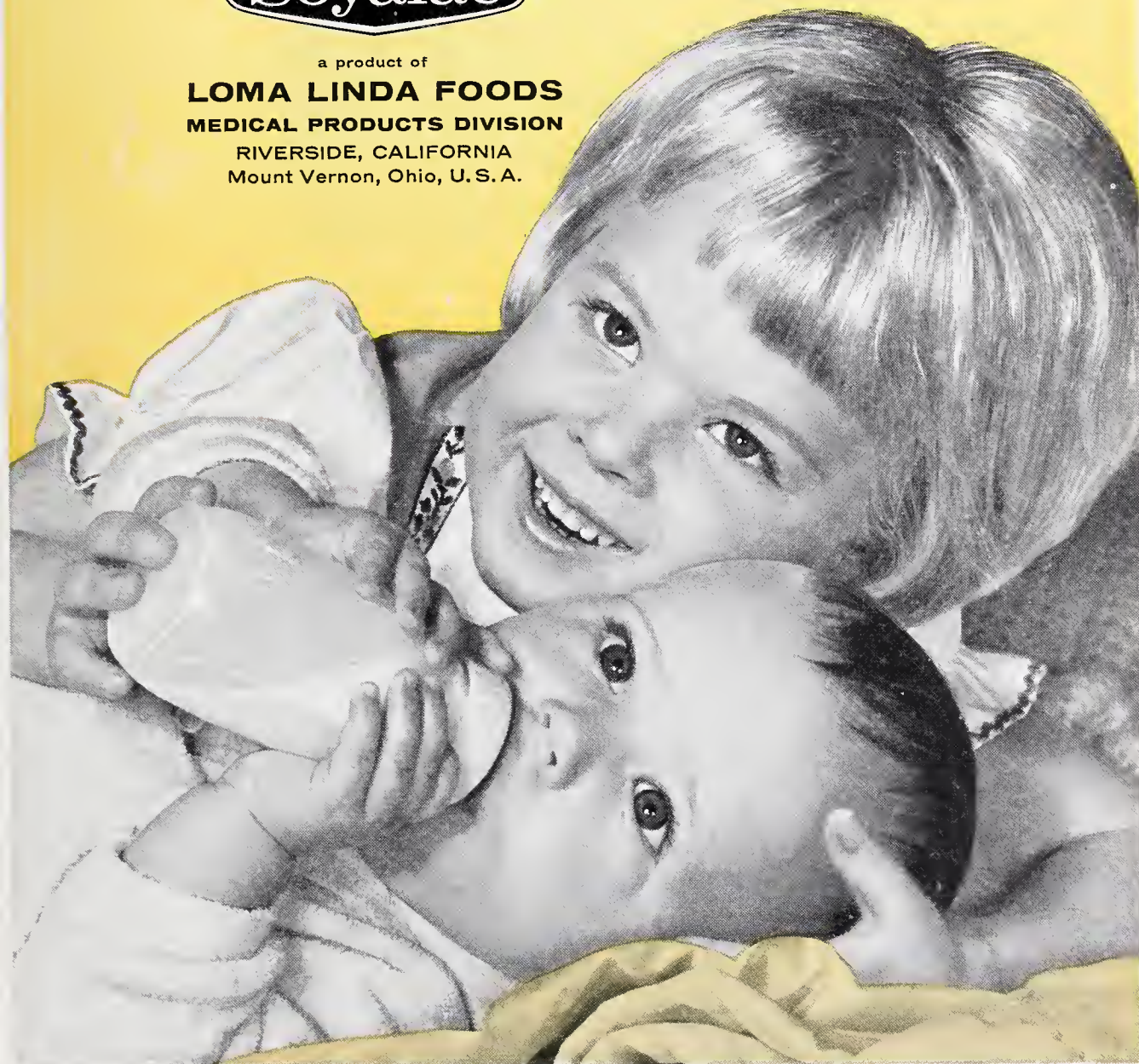
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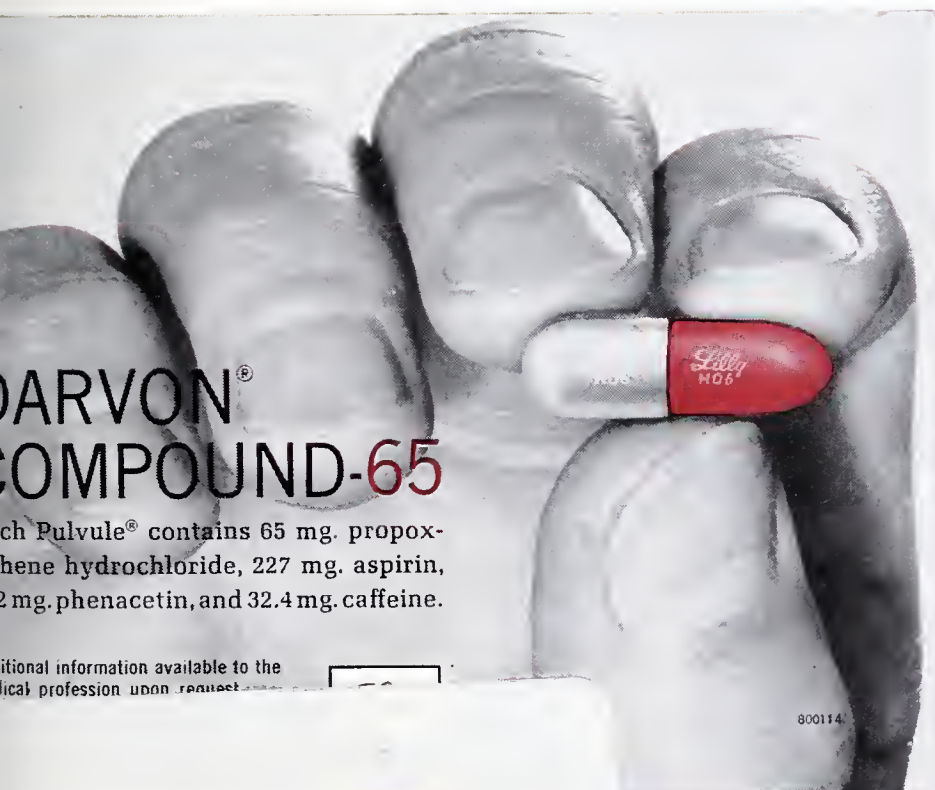
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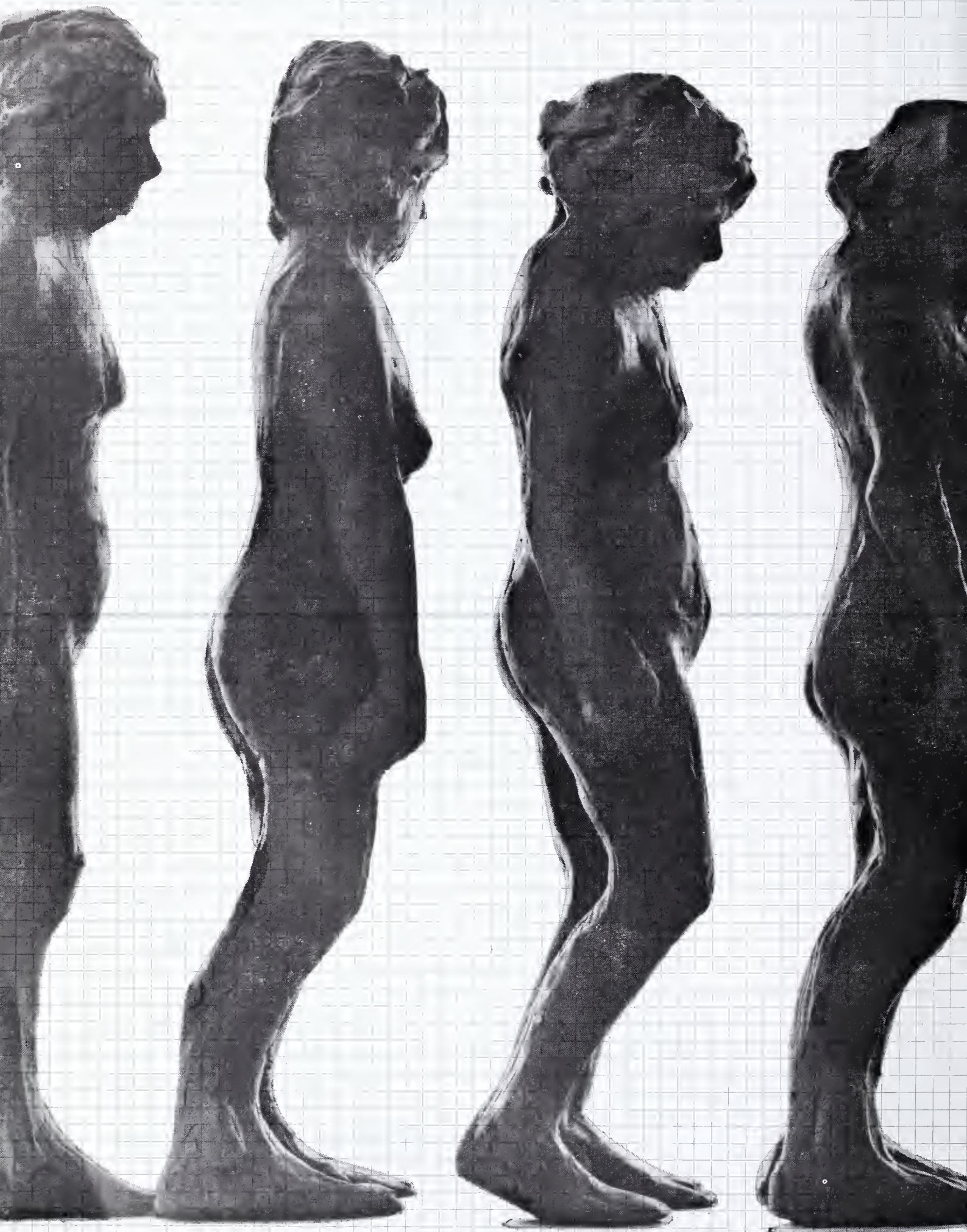
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In normal adults of average height, the midway point of the body is the top of the symphysis pubis. In osteoporotic patients, however, the measurement above this point decreases as spinal bone deteriorates, while the lower measurement remains basically unchanged. This disproportion, caused by shortening of the upper measurement or trunk, may be the first sign of osteoporosis—especially after the menopause—even before low back pain occurs and before irreversible bone changes show up on x-rays.

The correlation between loss of height and estrogen deficiency in the postmenopausal woman is amply confirmed by Henneman and Wallach.³ These investigators found that the longer the interval between the menopause and the institution of estrogen therapy the greater the loss in height. With replacement therapy, there was little or no further height loss. In women on replacement therapy from the time of the menopause, loss of height failed to develop.

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Indications: (1) Postmenopausal osteoporosis (after a natural or artificial menopause); (2) osteoporosis due to immobilization—atrophy of disuse—(patient with fracture, bedridden, inactive); (3) corticosteroid osteoporosis following cortisone-like hormone therapy; (4) osteoporosis due to malnutrition (notably protein depletion and ascorbic acid deficiency).

Contraindication: Carcinoma of the prostate, because of the methyltestosterone component.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosage Regimens: 1 tablet daily. *In the female:* To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period). *In the male:* A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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Supplied: No. 883—FORMATRIX Tablets, in bottles of 60 and 500.

1. Dent, C. E., and Watson, L.: *Postgrad. Med. J.* 42:(suppl.) 583 (Oct.) 1966. 2. Smith, R. W., Jr. Presented at meeting of Federation of American Societies for Experimental Biology, Chicago, 1967. Reported in *Medical World News* 8: 34 (May 19) 1967. 3. Henneman, P. H., and Wallach, S.: *Arch. Intern. Med.* 100:715 (Nov.) 1957.



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Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units). Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

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continue treatment for a much longer period. Clothing should be boiled to prevent reinfection.

Supply: 5 oz. polyethylene squeeze bottle.

*McClarin, W. M., and Knox, J. M.: *Cutis* 3:619 (June) 1967.

†The MICEL A[®] base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.



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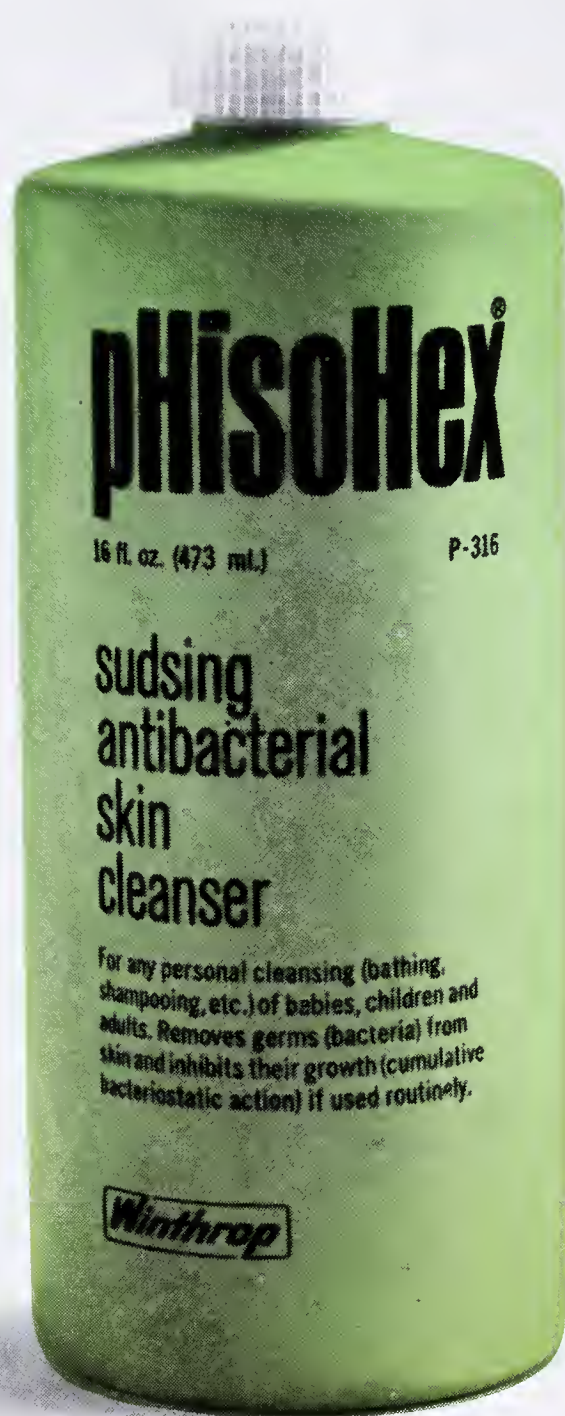
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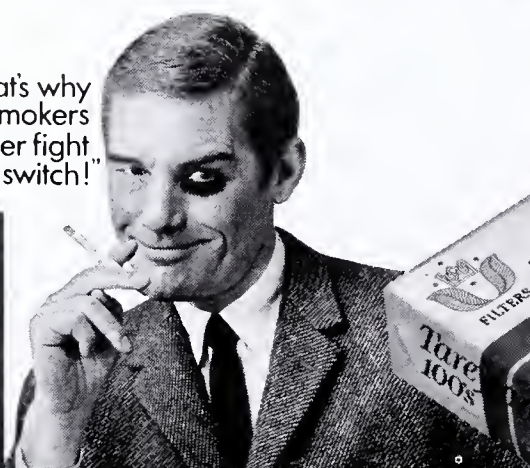


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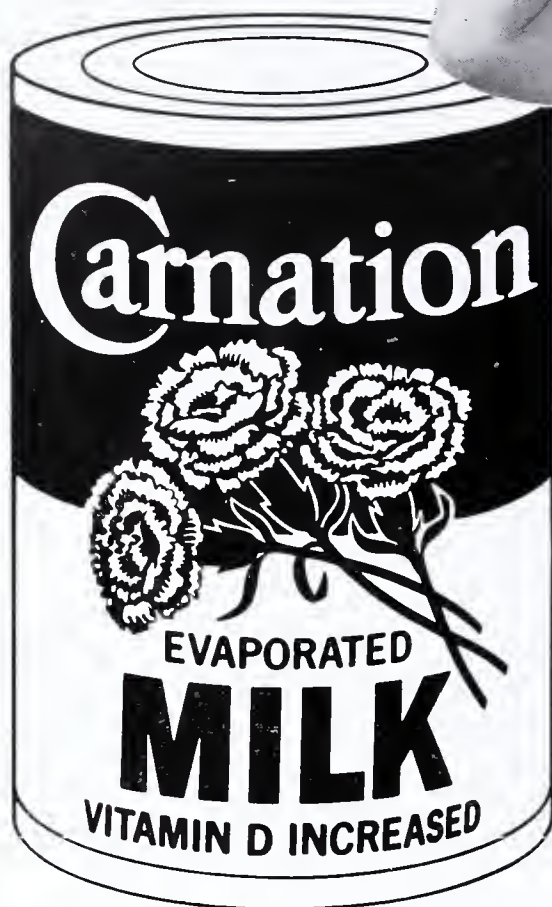
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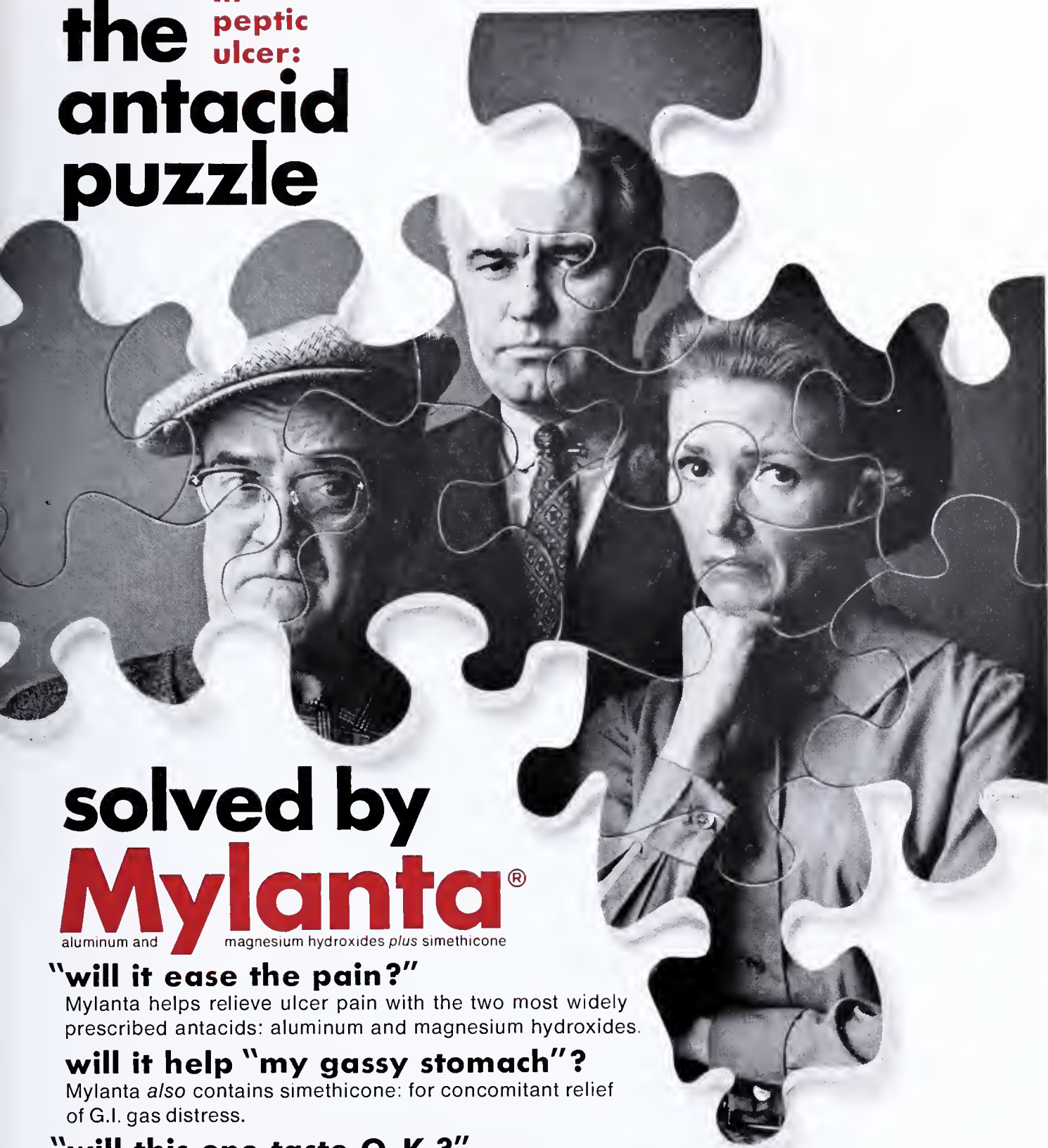


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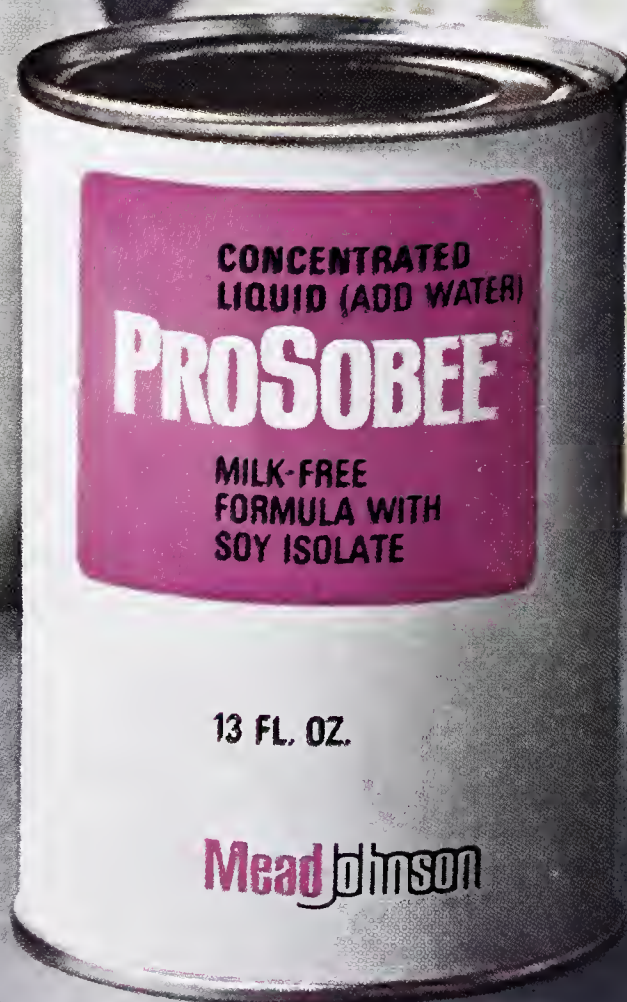
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1. Harkins, R. W., and Sarett, H. P.: J. Nutrition 91:213-218 (Feb.) 1967.

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Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K[®] (Potassium Phenoxyethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K[®] (potassium phenoxyethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful).

[042567A]

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Additional information available to physicians upon request.

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*Five cases of this rare cardiac anomaly, one of them unique,
with catheterization studies in all and autopsy in four.*

Double-Outlet Right Ventricle*

LOREN W. MARTIN, MAJOR, USA, MC,[†] MELVIN D. CHEITLIN, LT. COL., USA, MC,[§]
and JAMES A. ORBISON, COL., USA, MC,[‡] Honolulu

• *Five cases of double-outlet right ventricle without pulmonary stenosis show how closely this condition resembles either a simple ventricular septal defect with pulmonary hypertension or tetralogy of Fallot. One of the five cases presented is believed to represent a unique anatomical variation of the double-outlet right ventricle: intact interventricular and interatrial septa and atresia of the mitral valve.*

WITHAM IN 1957 introduced the term double-outlet right ventricle to designate an anomaly of the heart and great vessels, then believed to be rare, in which both the aorta and the pulmonary artery arise from the right ventricle.¹ He reported four cases of his own and summarized six from the literature. His purpose was to focus attention on the clinical pathologic correlation which he felt was lacking in the preceding literature. The primary anatomical features influencing the clinical presentation, in his opinion, were the existence of pulmonary stenosis, patency of the ductus arteriosus, and aortic coarctation. Accordingly, he divided his cases into two groups which he called the "Fallot type" and the "Eisenmenger type," based primarily on the presence or absence of pulmonary stenosis.

Neufeld *et al* in 1962 reported ten cases of double-outlet right ventricle without pulmonary stenosis in which the clinical and hemodynamic findings were correlated with the location of the ventricular septal defect.² According to their pro-

posed classification, when the ventricular septal defect was located below the crista supraventricularis it was designated as Type I, and when the ventricular septal defect was above the crista supraventricularis it was designated as Type II. Type II was subclassified as either A or B depending on whether the defect was closely related only to the pulmonary valve (Taussig-Bing complex) or whether it was more extensive and was related to both the pulmonic and aortic valves.

Since 1962 other series of cases have been reported stressing electrocardiographic and angiographic abnormalities which characterize each of the above types of double outlet right ventricle.³⁻⁴ In 1964, MacMahon and Lipa,⁵ followed shortly by Ainger,⁶ reported two patients in which the interventricular septum was intact, with oxygenated blood entering the right heart through an interatrial septal defect. The mitral valve in both cases was small and in one case was thickened and deformed.

The purpose of this report is to present the clinical and pathological features of five additional patients with double-outlet right ventricle. One of the cases is unique from an anatomical standpoint and will be reported separately.⁷ Four of these patients were born at Tripler General Hospital in Honolulu, Hawaii, within a period of fourteen months.

CASE REPORTS

CASE 1.—This 3½-year-old Caucasian boy was the product of a normal gestation and delivery. The neonatal period was uncomplicated except for circumoral cyanosis on crying. The child developed congestive failure at age seven months, when a Grade I/VI systolic murmur was first reported. Electrocardiograms revealed biventricular hypertrophy and chest films demonstrated dif-

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FIG. 1.—Composite photograph of PA chest films of each case taken at time of last hospital admission. Refer to case reports for detailed description.

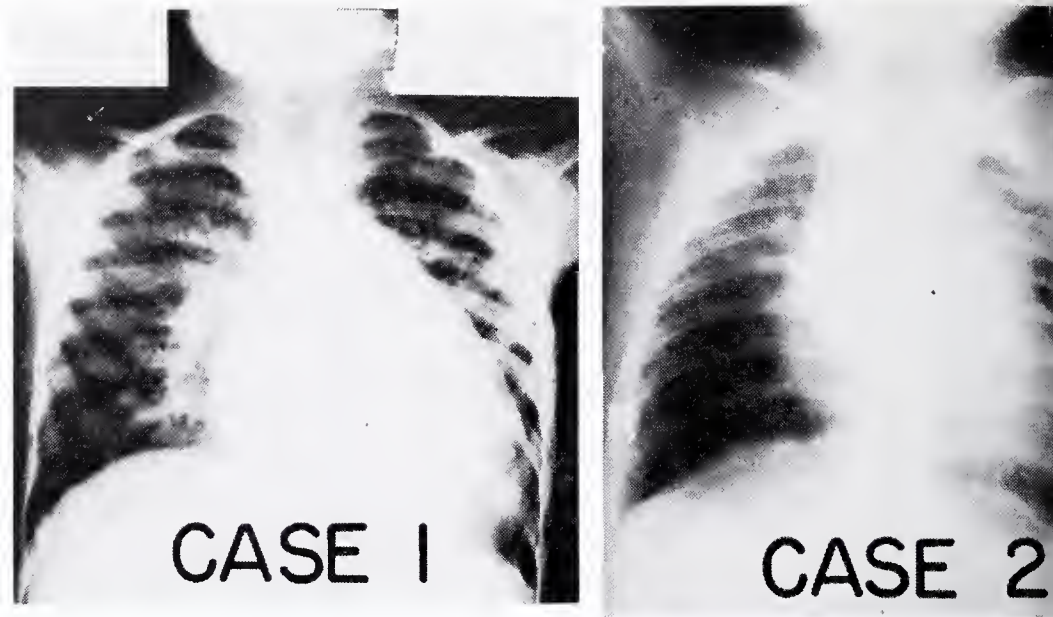


FIG. 2.—Composite photograph of ECG's of each case taken at time of last hospital admission. Refer to case reports for detailed description.

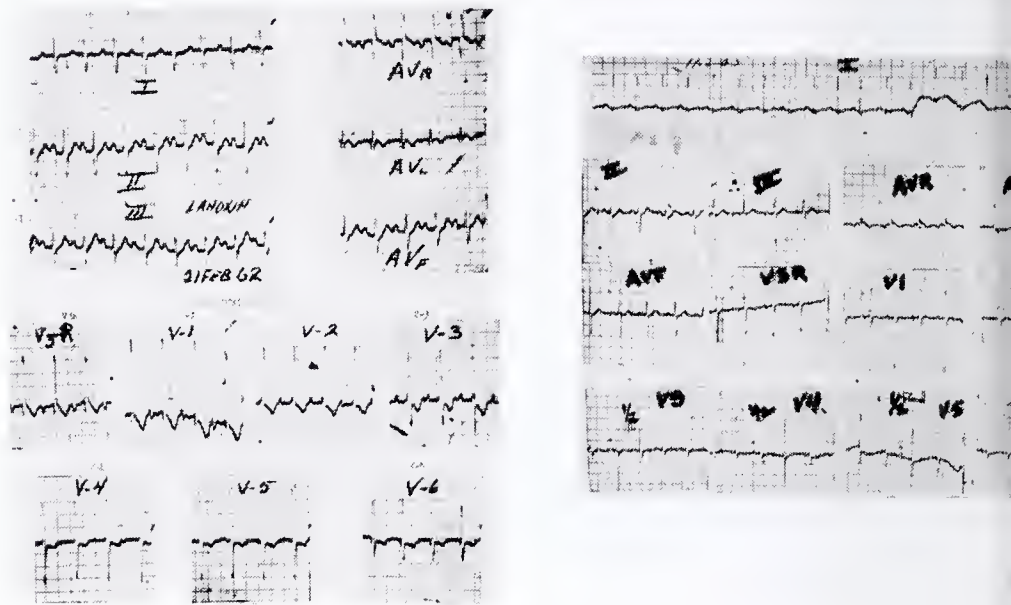
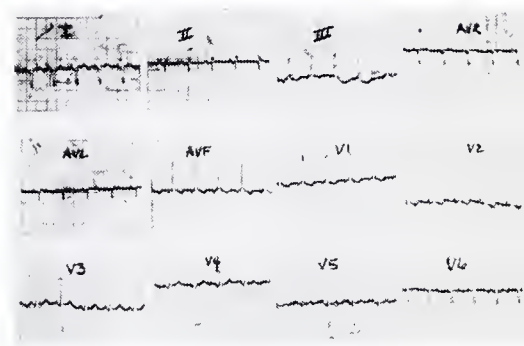
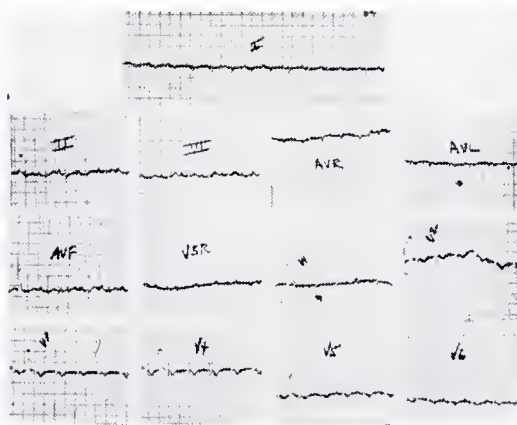
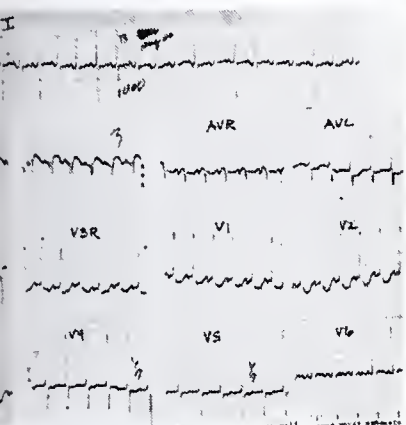
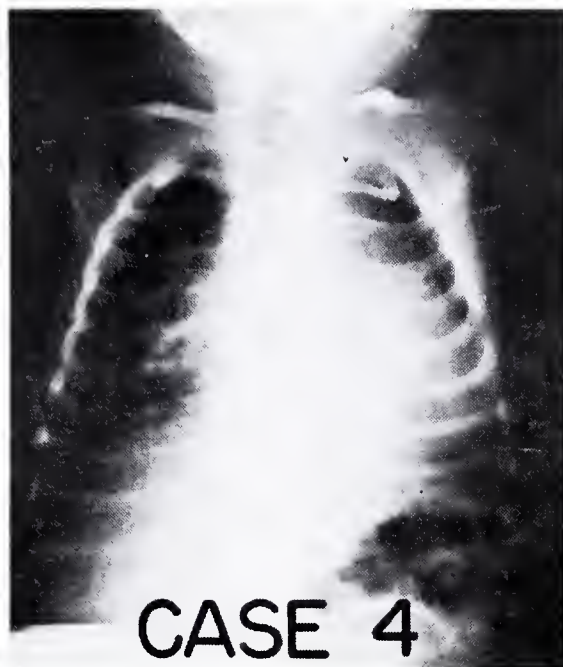


TABLE 1.—Cardiac Catheterization Data.

CASE NUMBER:	1		2		3		4	
LOCATION	PER CENT O ₂ SATURATION	PRESSURE	PER CENT O ₂ SATURATION	PRESSURE	PER CENT O ₂ SATURATION	PRESSURE	PER CENT O ₂ SATURATION	PRESSURE
SVC	69.0	.....	64.3	.....	76.0	.....	52.0	.....
RA	73.0	13/3	70.0	a-8 v-5	81.3	9/6	60.0	a-12 v-11
RV	87.0	80/0-10	76.0	88/-3-8	78.0	112/0-10	67.8	122/2-12
PA	88.0	80/32	79.0	86/7-15	.....	.....	.....	115/55
Wedge	.....	.....	.....	18/9	.....	.....	.....	.....
Systemic Artery	95.0	90/62	.....	.....	.....	.....	72.0	85/72
LV	.....	.....	94.0	90/0-8	86.5	112/0	86.0	112/6-13
LA	.....	.....	.....	a-8-12 v-8-16	88.0	14/9	.....	.....
ASSOCIATED CARDIAC ANOMALIES	1. 1 cm VSD below crista		1. VSD, believed to be below crista 2. Mild bilateral pulmonary artery stenosis at origins.		1. 0.5 cm VSD above crista 2. Patent ductus arteriosus 3. Coarctation of aorta		1. VSD above crista 2. 4 mm IASD 3. Patent ductus arteriosus 4. Coarctation of aorta	



fuse cardiomegaly with pulmonary plethora. The patient was digitalized, with good symptomatic response. At age 15 months the patient was re-evaluated because of poor growth. Pertinent physical findings at that time revealed a left parasternal systolic thrill and a harsh pansystolic murmur with maximum intensity along the left fourth intercostal space. The pulmonic component of the second sound was accentuated. The patient was continued on digitalis and at age 3½ years was seen at Fitzsimons Army Hospital. The mother stated that the child had continued to grow poorly. Pertinent physical findings at that time were limited to the cardiovascular system. The precordium was hyperactive with a prominent left ventricular thrust. Auscultation revealed accentuation of the pulmonic component of the second sound. A high-pitched pansystolic murmur was noted along the left sternal border, as well as an early diastolic flow murmur at the apex. Chest films revealed generalized cardiomegaly with pulmonary plethora (Fig. 1). Electrocardio-

grams revealed biventricular hypertrophy with a superiorly oriented counterclockwise loop in the frontal plane (Fig. 2). Cardiac catheterization (Table 1) revealed equal systemic pressures in the right ventricle and pulmonary artery. An increase in oxygen saturation of 2.2 volumes per cent was present at the level of the mid-right ventricle. Angiocardiograms were not performed. The patient was clinically believed to have a large ventricular septal defect with a left-to-right shunt. He was subsequently scheduled for surgery because of further clinical deterioration. At the time of surgery it was first realized that the patient had both great vessels arising from the right ventricle with a large ventricular septal defect. No corrective procedure was attempted. Twelve hours following surgery the patient developed A-V dissociation, followed shortly by cardiac arrest. Resuscitative efforts were unsuccessful. At autopsy the significant pathology was limited to the cardiovascular system. The heart was enlarged and globular. The external relationship

of the great vessels was normal. Both great vessels arose from the right ventricle with the aorta arising just to the right and slightly posterior to the pulmonic valve at the same level. A ventricular septal defect 1 cm in diameter was located below the crista supraventricularis. Examination of the great vessels revealed only minimal thickening and atherosclerotic changes of the intima of the pulmonary artery.

CASE 2.—This four-month-old American Indian boy was delivered at term after an uneventful gestation. A murmur believed to represent a ventricular septal defect was first detected at age six weeks during a well-baby visit. At age two months the child was brought to the hospital because of irritability, poor feeding habits, and cyanosis with crying. Examination revealed findings of congestive failure, for which he was admitted and digitalized. He responded well and was followed as an outpatient without further difficulty.

The significant physical findings on admission consisted of an active precordium with a palpable systolic thrill along the left sternal border. The pulmonic component of the second sound was accentuated. A harsh Grade IV/VI holosystolic murmur heard best in the 3rd and 4th intercostal spaces along the left sternal border was noted, as was a Grade II/VI apical diastolic flow murmur. The liver was palpable two fingerbreadths below the right costal margin.

Chest films demonstrated an enlarged left atrium and left ventricle with accentuation of the vascular markings (Fig. 1). Electrocardiograms revealed left axis deviation with a counterclockwise and superiorly oriented loop in the frontal plane and biventricular hypertrophy (Fig. 2).

Cardiac catheterization (Table 1) revealed equal systolic pressures in the right ventricle and main pulmonary artery with a nine per cent oxygen step-up observed at the level of the right ventricle. Pulmonary blood flow was twice systemic blood flow. Systolic gradients of 40 mm of mercury were demonstrated across the origins of both the right and left pulmonary arteries. Angiocardiograms demonstrated normally related great vessels in the AP projection. However, lateral views revealed simultaneous filling of both great vessels, with both the pulmonary artery and the aorta originating anterior to the ventricular septum.

A clinical diagnosis was made of double-outlet right ventricle with an interventricular septal defect (Type I) associated with mild bilateral pulmonary artery stenosis at their origin.

CASE 3.—This one-month-old Caucasian boy was admitted because of the mother's complaint

of a weak cry and a clinical diagnosis of congestive heart failure. The child was born at term following an uneventful gestation and delivery. Prior to discharge from the hospital an "innocent murmur" had been detected. At five days of age the family noted a weak cry and neighbors commented on the child's blue appearance. On the evening prior to admission the parents noted a slight cough associated with respiratory difficulty.

Pertinent physical findings revealed systolic blood pressures by flush technique of 150 mm Hg in the arm and 90 mm Hg in the leg. Inspiratory rales were audible in the lung bases. Examination of the heart revealed an active precordium with a left parasternal systolic thrill. A Grade IV/VI harsh systolic murmur was heard over the precordium with greatest intensity along the left sternal border. Abdominal examination revealed a palpable liver 3 cm below the right costal margin.

Chest films demonstrated diffuse cardiomegaly with pulmonary plethora and a diffuse patchy infiltrate throughout both lung fields (Fig. 1). Electrocardiograms revealed sinus tachycardia, biventricular hypertrophy, and a counterclockwise loop (Fig. 2). Right heart catheterization (Table 1) demonstrated systemic pressures in the right ventricle. Oxygen saturations were similar in the right atrium and ventricle, showing no left-to-right shunt by oxygen data. The left ventricle, entered through an interventricular septal defect, revealed an oxygen saturation of 86.5 per cent in spite of the child's breathing 100 per cent oxygen. Angiocardiograms demonstrated both great vessels arising from the right ventricle. The aorta revealed a long hypoplastic segment of coarctation beginning after the origin of the innominate artery. The left common carotid and subclavian arteries arose from the hypoplastic segment. A patent ductus arteriosus filled the distal aorta beyond the coarctation (Fig. 3).

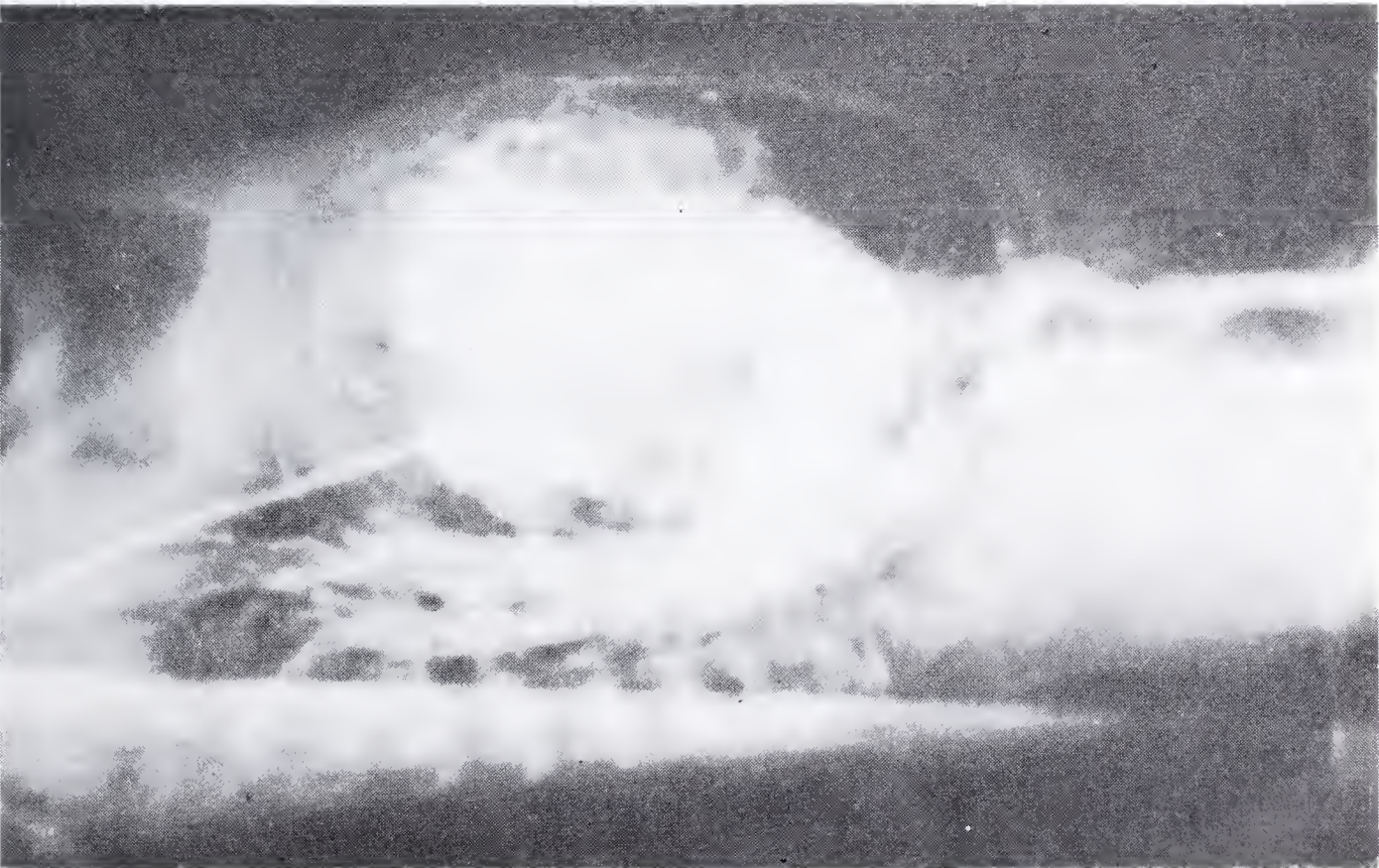
During the remainder of the child's hospitalization, we tried to compensate the cardiovascular status through the use of digitalis, diuretics, and supplemental therapy. His clinical condition progressively deteriorated and after two months he expired.

Autopsy revealed an enlarged heart weighing 112 grams. The predominantly enlarged chambers were the right atrium and right ventricle. The great vessels appeared normally related externally. There was a coarcted segment of aorta distal to the innominate artery, from which the left common carotid and left subclavian artery arose. A large patent ductus became continuous with the aorta distal to the coarctation. Both great vessels arose from the right ventricle. An interventricular

FIG. 3A.—Case 3 (right): PA film taken 1.25 seconds following injection into right ventricle. Note simultaneous filling of both great vessels.



FIG. 3B.—Case 3 (below): Left lateral film taken 1.25 seconds following injection into right ventricle. Note simultaneous filling of both great vessels and that they both arise anterior to the plane of the interventricular septum.



septal defect 0.5 cm in greatest diameter was present above the crista supraventricularis. The aortic valve was found to lie in the right ventricle directly above the interventricular septal defect.

CASE 4.—This 12-day-old Caucasian boy, second of twins, was referred for evaluation of a congenital heart lesion. The gestation and delivery were uncomplicated and his twin was in apparent

good health. Prior to discharge a murmur was noted but was believed to be innocent. Following discharge the child ate poorly and was noted to be lethargic and cyanotic. The patient was seen by a local physician on the day of admission and referred for evaluation.

The child had a sinus tachycardia and a systolic blood pressure by flush technique of 140 mm Hg

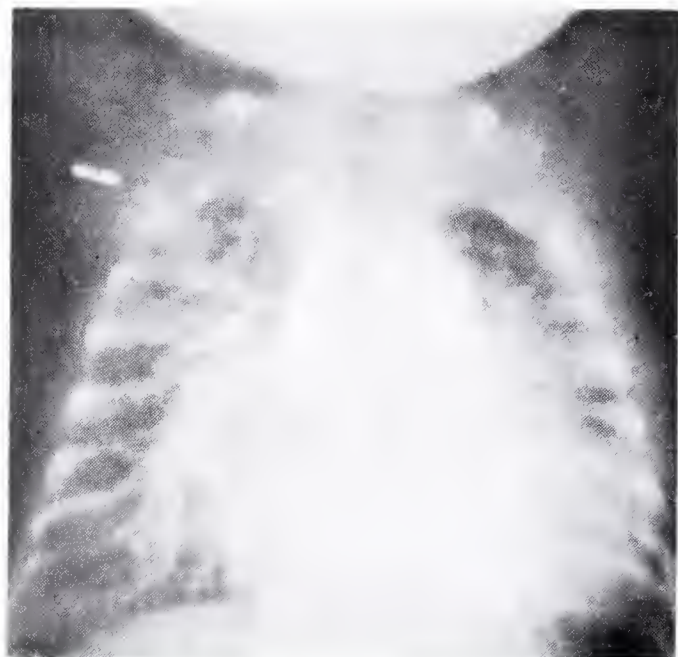


FIG. 4A.—Case 4 (left): PA film taken 1.0 sec. following injection into right ventricle. Both great vessels fill simultaneously.

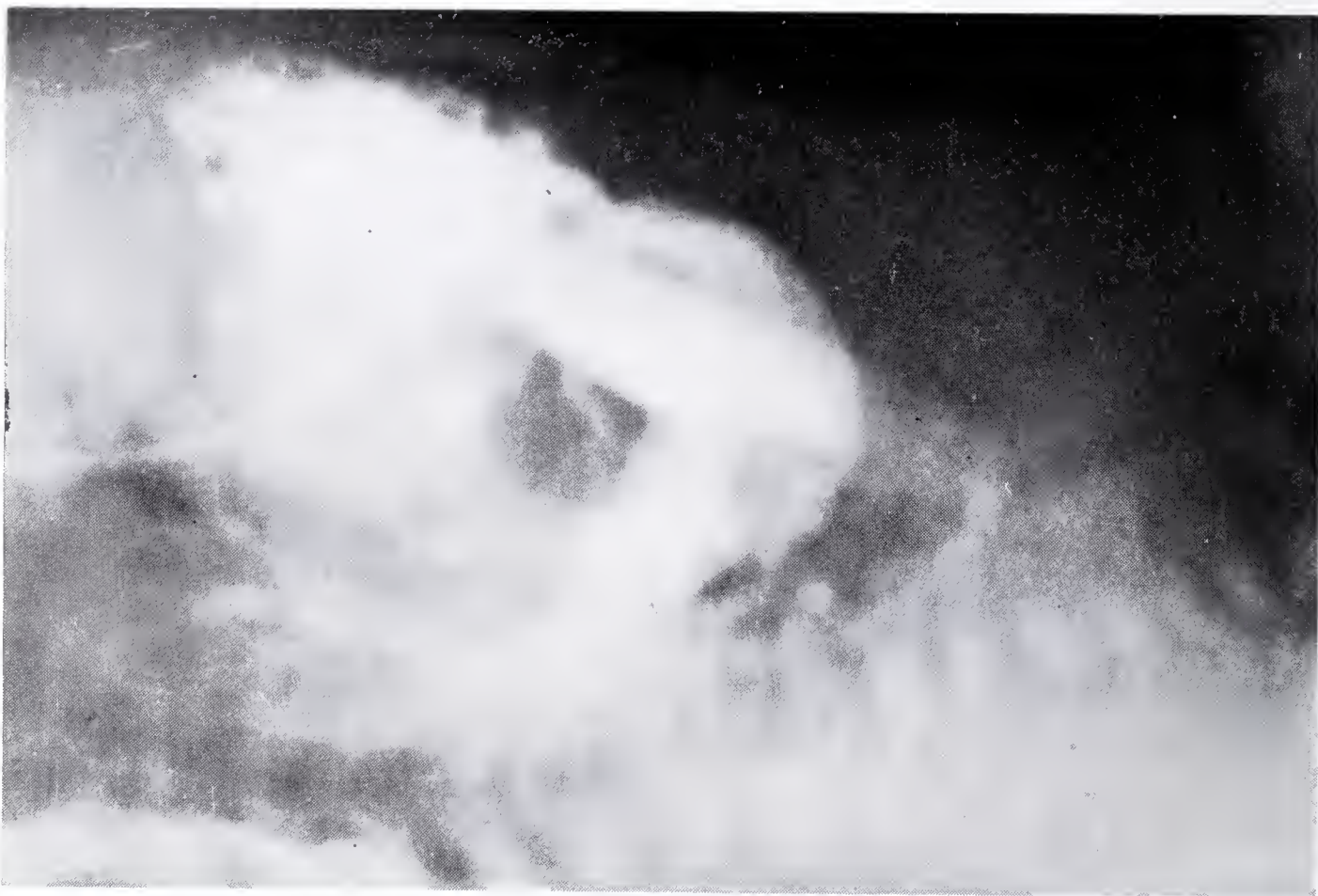


FIG. 4B.—Case 4 (below): Left lateral film taken 1.0 sec. following injection into right ventricle. Both great vessels fill simultaneously and note that they arise anterior to the plane of the interventricular septum.

in the arm and 90 mm Hg in the legs. The second heart sound was accentuated and an intermittent diastolic gallop was present. A harsh Grade III/VI systolic murmur was heard best along the left sternal border. The liver was palpable 3 cm below the right costal margin. Pitting edema of the feet was present.

Chest films demonstrated generalized cardiomegaly and pulmonary plethora (Fig. 1). Electrocardiograms were normal for age (Fig. 2).

Cardiac catheterization (Table 1) revealed equal systemic pressures in the pulmonary artery and right ventricle. An oxygen step-up of 7.8 per cent saturation occurred at the level of the right ventricle. The catheter was manipulated through the patent ductus arteriosus into the descending aorta where a pressure of 85/72 was recorded with an oxygen saturation of 72 per cent. Right ventricular angiograms revealed simultaneous filling of the great vessels (Fig. 4). The aorta was one-third the

diameter of the pulmonary artery and was coarcted distal to the left common carotid artery. The left subclavian artery arose from the coarcted segment. Contrast media filled the distal aorta through the patent ductus arteriosus. Lateral views demonstrated both great vessels arising anterior to the interventricular septum.

Shortly after the child was returned to the ward he developed seizures, with cardiac arrest, and expired.

At autopsy the heart was found to be enlarged, with the great vessels normally related externally. Both great vessels arose from the right ventricle. An interventricular septal defect was present above the crista supraventricularis. The location and relationship of the coarcted aorta is described above. Additional abnormalities included a four-mm interatrial septal defect and six pulmonary veins entering the left atrium. The immediate cause of death was rupture of the right ventricle, with hemopericardium.

CASE 5.—This newborn Caucasian girl was the term product of an uncomplicated gestation and delivery. Shortly following delivery she developed tachypnea and mild cyanosis.

Physical examination at this time revealed basilar rales and generalized rhonchi. The cardiac examination revealed sinus tachycardia. No cardiac murmurs were heard.

Chest films revealed coarse nodular densities bilaterally, with air-bronchograms extending to the periphery. The heart size was normal (Fig. 1). Repeat films showed worsening of this process with the development of pleural effusion. Serial ECG's demonstrated sinus tachycardia, severe right axis deviation, and right ventricular hypertrophy (Fig. 2).

The infant was treated symptomatically with the clinical diagnosis of neonatal atelectasis or pneumonia. The cyanosis was easily controlled initially in the isolette. Subsequently the infant developed increased respiratory distress with congestive failure, requiring digitalization. Despite vigorous therapy the child's clinical course worsened and she expired on the sixth day.

Significant autopsy findings were limited to the pulmonary and cardiovascular systems. Pinkish foamy material oozed from the cut surface of the lungs and microscopic sections revealed diffuse atelectasis with focal hemorrhages. The heart revealed both great vessels arising from the right ventricle. A 0.3-cm ventricular septal defect was present superior to the crista supraventricularis. The mitral valve was completely atretic and there was no communication between the atria. Four pulmonary veins drained normally into the left

atrium. The azygous vein was larger than normal. It was believed that the oxygenated venous blood returned to the right heart through the azygous vein which drained anastomotic channels between pulmonary and bronchial veins.

DISCUSSION

As illustrated by the cases reported, the anatomical and clinical features in double-outlet right ventricle may be protean. None of our cases were associated with pulmonary stenosis and all would thus be classified as the Eisenmenger type, according to Witham.

NEUFELD TYPE I

The first two cases represent Neufeld's Type I division, in which both great vessels arise from the right ventricle with a ventricular septal defect located below the crista supraventricularis. It is important to emphasize that the aorta and pulmonary artery have a normal external appearance, with the ascending aorta lying to the right of the pulmonary trunk, as illustrated in Figure 5. However, the internal relationships of the great vessels



FIG. 5.—Case 1: Gross photograph of the heart. Note that the aorta and pulmonary artery appear to be normally related to one another in the frontal view.

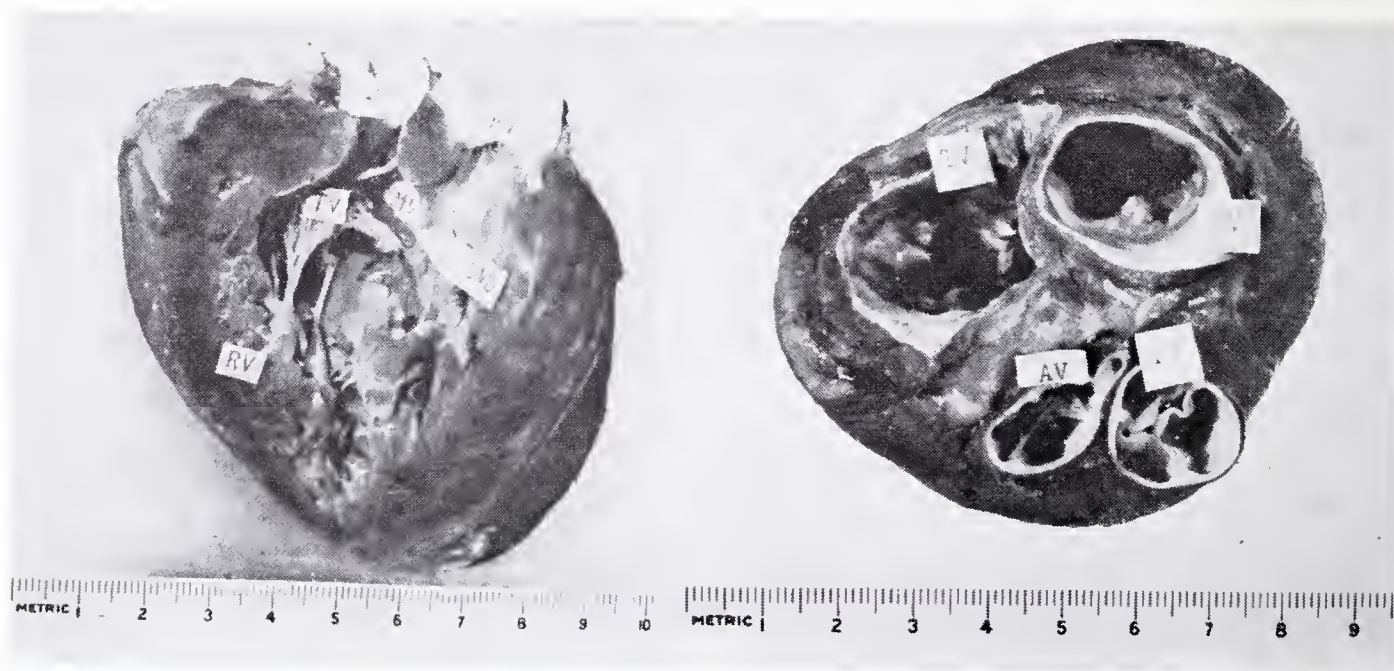


FIG. 6.—Right: Superior view of heart with atria removed. Note muscle mass separating mitral valve ring and aortic valve ring.

AV = aortic valve

PV = pulmonary valve

RV = right ventricle

SVD = ventricular septal defect

MV = mitral valve seen through SVD

TV = tricuspid valve

are grossly abnormal. As illustrated in Figure 6, the aorta originates entirely from the right ventricle and the aortic valve lies to the right of, and in the same coronal body plane as, the pulmonary valve. Notice also that in contrast to the normal heart, in which the anterior leaflet of the mitral valve is continuous with aortic valvular tissue, in this anomaly, in the majority of cases, the anterior leaflet of the mitral valve is separated from aortic valvular tissue by a muscular mass.

Patients with the Type I anomaly usually present clinically with only a cardiac murmur detected shortly after birth. Cyanosis is infrequent and when present is usually intermittent and mild. Congestive heart failure develops usually prior to six months of age and is the usual cause of death in these children. The only significant physical finding prior to development of congestive failure is a systolic murmur which in all respects is indistinguishable from the murmur heard in a simple ventricular septal defect. Pulmonary hypertension is usually present, so the second sound is often intensified.^{2, 8}

Electrocardiograms reveal a mean QRS axis between -70 and 100 degrees with the frontal

QRS vector loop directed either clockwise or counterclockwise. Right ventricular hypertrophy is evident in about 50 per cent of cases.

Chest x-rays demonstrate cardiomegaly, pulmonary plethora, and enlargement of the pulmonary artery.

Cardiac catheterization shows similar simultaneous pressures in the right ventricle and systemic arteries with oxygen saturations greater than 90 per cent in systemic arteries and much lower in the pulmonary artery. It is apparent from the catheterization data that mixing in the right ventricle is incomplete and most of the blood in the aorta is derived from the left ventricle. Injection of opaque media into the right ventricle reveals simultaneous filling of the great vessels with the pulmonary artery appearing more densely opacified. The aortic valve is found to lie unusually high and at the same coronal level as the pulmonary valve. If the patient is rotated to the left lateral or left anterior oblique position, the transposed aortic valve should appear anterior to the plane of the ventricular septum above the right ventricle as illustrated in Figure 4.

It is clearly evident that the clinical features of

this anomaly closely resemble those seen in patients with a large ventricular septal defect associated with pulmonary hypertension. The incorrect diagnosis of this entity, with subsequent closure of the ventricular septal defect has been reported, with obvious disastrous results. In recent years, it has become even more important to establish this diagnosis, as surgical correction is now possible.⁹ As illustrated in Case 1, the correct diagnosis is missed when catheterization alone is performed. Angiocardiography must be done in order to detect this lesion.

NEUFELD TYPE II

The third and fourth cases reported represent Neufeld's Type II division, in which the ventricular septal defect is located above the crista supraventricularis. The same anatomic relationship exists between the heart and great vessels. Patients present clinically with cyanosis which develops shortly after birth associated with a systolic murmur which is indistinguishable from the type of murmur noted in the usual large ventricular septal defect. Electrocardiograms reveal a mean QRS axis between +110 and 130 degrees with the vector loop in the frontal plane directed clockwise. Right ventricular hypertrophy is seen in all and left ventricular hypertrophy in 50 per cent of cases. Chest x-rays are similar to those in Type I. Cardiac catheterization is sharply contrasted from Type I in that marked desaturation is noted in the systemic peripheral arteries.^{2, 8} In subtype A (Taussig-Bing complex) in which the interventricular septal defect is closely associated with the pulmonary artery, the pulmonary oxygen saturation is much greater than in the systemic arteries, whereas in subtype B the oxygen saturation of both great vessels is identical. Angiocardiography is similar to that seen in Type I with the exception that a right ventricular injection causes the aorta to appear more dense than the pulmonary artery in Type II-A and reveals equal density of the great vessels in Type II-B.²

FALLOT-TYPE CASES

Although none of the cases discussed previously were associated with pulmonary stenosis, it is felt that this clinical entity deserves some comment, since it occurs in approximately 50 per cent of the reported cases of double-outlet right ventricle and because its clinical presentation is difficult to separate from tetralogy of Fallot. The clinical presentation in these children is that of cyanosis developing shortly after birth, associated with a ventricular septal defect murmur. The observation has been made that squatting is uncommon and that growth

retardation is greater in these patients than among those with other forms of cyanotic heart disease.⁸ In contrast to uncomplicated Types I and II, the chest films reveal cardiomegaly with markedly decreased pulmonary vasculature. The electrocardiogram in this entity is somewhat specific in that there is an almost constant association of right atrial enlargement, intraventricular conduction disturbances and severe right ventricular hypertrophy. A large per cent of patients also have left ventricular hypertrophy and a delayed atrioventricular conduction time.^{3, 8} Angiocardiography again demonstrates characteristic abnormalities. Although it is evident that this condition clinically mimics tetralogy of Fallot, the electrocardiogram demonstrating biventricular hypertrophy and A-V conduction defects should make this anomaly suspect, following which the diagnosis may be substantiated by angiocardiograms.

A UNIQUE ANOMALY

Case 5 presented above represents what we feel to be a unique anatomical form of this entity. As mentioned previously, there have been two reports of double-outlet right ventricle with an intact interventricular septum, with oxygenated blood reaching the right ventricle through an atrial septal defect. However, in this child, no atrial septal defect could be demonstrated and the mitral valve was completely atretic. It appeared at autopsy that oxygenated blood was being delivered to the right side of the heart by way of pulmonary veins draining through anastomoses into bronchial veins which emptied into an enlarged azygous system and then into the right heart. As indicated in the clinical history, cyanosis was evident from birth. It is quite apparent that this set of congenital anomalies is compatible with life only for a brief time.

ETIOLOGY

The etiology of this condition is unknown. Attractive theories have been proposed concerning the embryogenesis of transposition of the great vessels.¹⁰ In 1965, Rogers *et al*¹¹ reported on nine autopsied patients with the clinical features of the trisomy-18 syndrome (four confirmed by chromosomal analysis) and observed that seven had a double-outlet right ventricle with associated ventricular septal defect. It was their opinion that this condition might represent an additional component of the trisomy-18 syndrome.

DIAGNOSIS

This entity is probably not as rare as it was believed to be by earlier authors. As indicated

previously, these children may clinically present as either a simple ventricular septal defect with pulmonary hypertension or as tetralogy of Fallot. Cardiac catheterization alone will not make the correct diagnosis, as illustrated in Case 1. When the clinical picture is combined with angiocardiography, the correct diagnosis should be substantiated. It is believed that the true incidence of this entity is higher than generally appreciated as many are misdiagnosed because of failure to demonstrate the relationships of the great vessels at the time of catheterization by angiocardiography. If

this condition is not clinically recognized prior to surgery, disastrous results should be expected following closure of the ventricular septal defect.

Whenever a child presents with what is clinically felt to represent either a ventricular septal defect or Tetralogy of Fallot, double-outlet right ventricle must be considered and clinical clues to the proper diagnosis should be searched for primarily in the electrocardiogram. An essential part of the diagnostic evaluation must be angiocardiographic studies prior to corrective surgical procedures in order to exclude this anomaly.

REFERENCES

1. Witham, A. C.: Double outlet right ventricle, *Amer. Heart J.* 53:928-939 (June) 1957.

2. Neufeld, H. N., Lucas, R. V., Jr., Lester, R. G., Adams, P., Jr., Anderson, R. C., and Edwards, J. E.: Origin of both great vessels from the right ventricle without pulmonary stenosis, *Brit. Heart J.* 24:393-408 (July) 1962.

3. Mirowski, M., Mehrizi, A., and Taussig, H. B.: The electrocardiogram in patients with both great vessels arising from the right ventricle combined with pulmonary stenosis, *Circulation* 28:1116-27 (Dec.) 1963.

4. Engle, M. A., Steinberg, I., Lukas, D. S., and Goldberg, H. P.: Acyanotic ventricular septal defect with both great vessels from the right ventricle, *Amer. Heart J.* 66:755-766 (Dec.) 1963.

5. MacMahon, H. E., and Lipa, M.: Double-outlet right ventricle with intact interventricular septum, *Circulation* 30:-745-748 (Nov.) 1964.

6. Ainger, L. E.: Double-outlet right ventricle: intact ventricular septum, mitral stenosis, and blind left ventricle, *Amer. Heart J.* 70:521-525 (Oct.) 1965.

7. Martin, L. W., Cheitlin, M. D., and Labiche, H. M., Jr.: Double outlet right ventricle with complete mitral atresia and premature closure of atrial septum (to be published).

8. Mehrizi, A.: The origin of both great vessels from the right ventricle, *Bull. Hopkins Hosp.* 117:75-90 (Aug.) 1965.

9. Kirklin, J. W., Harp, R. A., and McGoon, D. C.: Surgical treatment of origin of both vessels from right ventricle, including cases of pulmonary stenosis, *J. Thorac. Cardio. Surg.* 48:1026-1036 (Dec.) 1964.

10. Grant, R. P.: The morphogenesis of transposition of the great vessels, *Circulation* 26:819-840 (Nov.) 1962.

11. Rogers, T. R., Hagstrom, J. W. C., and Engle, M. A.: Origin of both great vessels from the right ventricle associated with the trisomy-18 syndrome, *Circulation* 32:802-807 (Nov.) 1965.

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CHRISTMAS

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We'll bet you wouldn't have guessed how effective and ambitious a School of Public Health we have in Manoa!

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RICHARD K. C. LEE, M.D., Dr.P.H.,* and
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● *The University of Hawaii's School of Public Health, like other schools of public health, is committed to training as many persons as possible to help alleviate the national shortage of health workers. With public demands for improved health services such as better child care, improved treatment of the mentally ill and the mentally retarded, control of environmental hazards, comprehensive health planning, and improved skills in health services administration, it behooves all schools to assist Federal, State, and local governments and health agencies to take the necessary steps to assure an adequate supply of well-qualified health personnel. The School of Public Health, University of Hawaii, is dedicated to contributing its share in increasing the nation's pool of health manpower, conducting appropriate health research, and offering direct services to the community.*

The School is a young school; it is less than six years since it was established and less than three years since its accreditation by the American Public Health Association. Its growth has been rapid in the six years of its history. There were two degree candidates in the fall of 1962; there were 72 degree candidates last fall. In the 1962-63 academic year, there were 3.34 full-time faculty members and several part-time lecturers; there are now about thirty full-time faculty members.

The rapid growth of the School is perhaps typical of schools of public health and other professional schools throughout the country. It should be noted, however, that the swift expansion occurred within a university which, as a whole, has experienced a rate of growth probably not anticipated by the University's administration and community even as recently as five years ago. Just five years ago, there were 9,150 daytime students on the Manoa campus; today there are 16,500,* an increase of 80 per cent.

THE UNIVERSITY OF HAWAII'S School of Public Health, like all other schools of public health, is committed to promoting the community's health and well-being. The three major objectives of the School in Hawaii are (1) to provide instruction in the health sciences to graduate students and to professional community health workers; (2) to encourage, develop, and conduct appropriate research with particular reference to the Hawaiian and Asian-Pacific areas; and (3) to participate, whenever feasible, in community-health services, including the provision of consultative and public education services.

UNIVERSITY OF HAWAII

The University of Hawaii, the only state university in Hawaii, is a Federal land-grant institution founded in 1907. The main campus is located in the Manoa Valley section of Honolulu; a second campus in Hilo, on the island of Hawaii, offers a two-year undergraduate program.

There are eleven colleges and schools; the colleges of Arts and Sciences, Business Administration, Education, Engineering, General Studies, and Tropical Agriculture, and the schools of Nursing, Public Health, Social Work, Medicine, and Library Studies. The latter two schools were established within the last three years. In addition, a

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* Includes 2,600 graduate students; excludes 3,000 evening credit-course students.

statewide system of community colleges, under the general supervision of the University, was also recently established. Additional research institutes in the various disciplines as well as a new graduate research library have also been established. In short, there has been growth of students, faculty, professional schools, budgets, buildings, research, international programs, and continuing education. The rapid development of the School of Public Health, then, is largely symptomatic of what is happening throughout the University of Hawaii.

EAST-WEST CENTER

Adjoining the main University campus is the Center for Cultural and Technical Interchange between East and West, more popularly called the East-West Center. It is a national institution, created by Congress in 1960. It is headed by a Chancellor and operated in association with the University of Hawaii. The Center's principal objective is to contribute to and improve mutual understanding among the peoples of Asia, the Pacific area, and the United States. The Center does not provide classrooms or faculty as such, but it awards about 500 scholarships each year to Asian-Pacific and American students, usually graduate students, who study primarily at the University of Hawaii. The Center has sponsored about twenty graduate public health students, of whom five have been from the United States.

SCHOOL OF PUBLIC HEALTH FACILITIES

The School's projected plans call for an additional 10,000 sq. ft. in Classroom Building No. 4 and about 30,000 sq. ft. in the Biomedical Sciences Building by 1969 and 1970 respectively. Additional space will be required if the School is expected to offer additional instructional programs and expand its research, continuing education and community service activities.

PHILOSOPHY OF THE SCHOOL OF PUBLIC HEALTH

The essence of public health practice is the skill and wisdom with which a community's resources are mobilized and organized to achieve optimum physical and mental health and social well-being by all the people. The scope of public health thus embraces a broad concern for action which will assure that comprehensive health and medical facilities and resources necessary to the needs of the community are present and utilized well.

The primary goal of our School is to foster within graduate students the skills and maturity to play professional roles in contributing to the diagnosis and solution of community health prob-

lems. Our programs seek to prepare people whose concern for the public health commits them to the total health interests of the people served rather than the more narrowly defined interests of a single agency or problem.

ORGANIZATION

The School is headed by a Dean, assisted by seven faculty committees: Executive, Admissions-Traineeships, Community Service and Continuing Education, Curriculum, Research, Space, and Long-Range Planning. The Dean is an ex officio member of all committees. He is assisted by an Associate Dean for Academic Affairs and an Assistant Dean for Administration. At present the School is organized formally into a single department, with the Dean as chairman, but it functions informally around fifteen areas of program emphasis. These areas are biostatistics, comprehensive health planning, environmental sanitation, epidemiology, health services administration, international health, maternal and child health, mental health, mental retardation, population and family planning studies, public health administration, public health education, public health engineering, public health laboratory services, and public health nutrition.

Formal establishment of separate departments may be appropriate in the future as student enrollment and faculty increase and doctoral programs are offered.

For purposes of coordinated program planning and review aimed at achieving the common goal of providing the best possible education, research and service in the health sciences, the schools of Medicine, Nursing, Public Health, and Social Work are organized into a College of Health Sciences and Social Welfare. The College is administered by an Executive Committee composed of the deans of the four schools and chaired by the Dean of the School of Medicine. In matters other than those affecting the health sciences as a whole and requiring consequent coordination among the four schools, each school remains autonomous with regard to its own conformance to accreditation requirements, preparation of its own budgets and recruitment of its own faculty.

DEGREE PROGRAMS

The School offers at present programs leading to the M.P.H. or M.S. degree. A student's curriculum, under either program, will reflect an area of concentrated study in addition to a few "core" courses required of all degree candidates.

A Dr.P.H. program is in the design stage at present, and hopefully the School will offer it beginning in the fall of 1969. It is planned that the

first Dr.P.H. program will emphasize health education. A Ph.D. program is also planned for a time when the School acquires more space, in about 1970. The first Ph.D. program will probably be in biometry, which will allow the doctoral candidate to major in either biostatistics or epidemiology, while minoring in the other.

ADMISSION REQUIREMENTS

Traditionally, degree candidates have been largely physicians, dentists, veterinarians, or other personnel in the health or related professions with at least three years of experience; however, schools of public health are now relatively more flexible in their admission requirements. At this School, applicants who have only bachelor's degrees are required to have had a minimum of 18 credit hours in the natural, social, and behavioral sciences in their undergraduate work. In addition, applicants who have had preparation in a discipline appropriate to their area of concentrated study are preferred. The kind of minimum previous academic preparation varies considerably with the chosen area of emphasis. For instance: biostatistics requires a substantial amount of previous work in mathematics; public health engineering requires a bachelor's degree in civil engineering; public health education requires a good grounding in the behavioral sciences; public health nutrition requires a B.S. degree in food and nutrition, dietetics, or one of the biological or physical sciences; and so forth.

Because of the severe national shortage of professional health workers, the School is obliged to train persons who show evidence of rather solid commitments to careers in public health. Consequently, an applicant's occupational objective is an important factor in the awarding of public health traineeships as well as acceptance to the School.

PERIOD OF STUDY

The total length of period of study varies from twelve to 24 months depending on the student's previous training, experience, and career goals. In general, most students require one and one-half years to complete their programs.

FIELD WORK

The majority of students undertake four to eight weeks of supervised field work, generally during the summer months, in a health agency in Honolulu, a neighbor island, one of the western states, or governments in the Pacific region. A student who receives a public health traineeship is restricted to field work in the United States and its

territories (the Trust Territory of the Pacific Islands is included), but a student sponsored by the East-West Center may go to an Asian country and do his field work. The latter opportunity has been most gratifying to our faculty since it not only provides the student with an excellent chance to work in an exotic setting but his experiences may serve as a subsequent teaching aid to improve the instructional and research programs of the School. One student spent a year in Nepal assisting in Nepal's first health survey as partial fulfillment of her master's degree. Her paper submitted at the end of her field work contained such a wealth of useful public health practices that the Peace Corps uses it in its training programs.

Another American student spent the summer at the Ateneo College in Manila, Philippines, doing research under the supervision of a faculty member of that institution. Five students were assigned to the Trust Territory of the Pacific Islands to conduct health studies. Many of our students including Asians have had their field work in health agencies in Hawaii and some of the Western states.

RESIDENCY PROGRAMS

A three-year residency program in general preventive medicine is being planned for the very near future. The program is designed for physicians interested in careers in research, teaching, or international health. The residency includes an academic year at the School and two years of field work with opportunity for training and experience in the field, epidemiologic research, international health, tropical medicine, microbiology, computer technology, genetics, and medical school teaching. The School is fortunate to have the resources of the School of Medicine and the State Department of Health to round out the residency program.

STUDENTS

From its inception in 1962, the School has always enjoyed a mixed student body of Asian-Pacific and American students. Of the 72 degree candidates enrolled last fall, 39 were from the mainland U.S., 20 from Hawaii, and 13 from the Asian and Pacific countries. The foreign students were from Indonesia, Japan, Korea, Malaysia, Philippines, Taiwan, Thailand, and Vietnam. In addition, there were eight special nondegree students from American Samoa, Fiji, and Taiwan.

Postdoctoral students (physicians, dentists, veterinarians), nurses, and sanitarians comprise more than half of the present student body. The remaining half includes health educators, school teachers, dietitians, physical therapists, and laboratory tech-

nicians. Of the 80 degree and special students, all except eight are supported by some form of financial aid. Most receive public health traineeships which are funded from a Public Health Service grant to the School; others are sponsored by the East-West Center, World Health Organization, Fulbright-Hays scholarship, and mainland state health departments. Present indications clearly point to an increase in the variety and number of sponsors in future years, and it is entirely possible that one day all of our full-time students will be assisted financially by some fund or agency.

By 1975, the School expects to have a student body of about 125 students, of whom about 55 will be entering master's degree candidates, about eight entering doctoral candidates, and about two physicians in the residency program. The remainder will be second and third year students. This is the maximum student load that the School hopes to maintain for an indefinite period.

The School presently offers three courses exclusively for medical students. It will continue to provide the preventive medicine component of the medical students' curriculum. The faculty of the School conducts the sanitary engineering course for the College of Engineering's graduate program in this area of specialization.

CONTINUING EDUCATION

In addition to the formal degree programs, the School of Public Health offers practitioners with educational experiences which extend and broaden their basic professional background and where necessary, make up for inadequate professional preparation. The primary objective of the continuing education program of the School is to provide professional health workers with the latest knowledge, techniques, developments, and trends in public health and related fields through short courses, workshops, seminars, institutes, and other appropriate media. While concern with specific content, techniques, and skills is fundamental, of equal importance to the continuing education program is the opportunity provided for professional interchange and multidisciplinary exploration of broad concepts and relationships within the health field.

In its first year of operation, the continuing education programs included three- to five-day seminars on public health law, communications, and nursing home administration; a weekly series, for 11 weeks, on recent developments in diet therapy; and a three and one-half day symposium on man and his total environment. Total attendance for the five offerings was 235, and represented persons not only from the health fields but

in areas such as social work, corrections, and law. Faculty for these offerings were drawn both from the academic world and the practitioner sector, from Hawaii and the mainland U.S. The offerings have been held both on and off campus, but more often the latter. In addition to the courses mentioned above, the continuing education staff has participated in the development and conduct of offerings by other schools and community agencies.

Another kind of continuing education that the faculty provides is the consultative, professional, and technical support given to the East-West Center's Institute for Technical Interchange. Consultation is furnished primarily to strengthen the Institute Staff's capability of determining continuing education needs of specific health personnel from the Pacific Basin countries. Through consultative services, classroom and community field activities for these public health workers are planned to meet their relevant needs. Health educators, sanitarians, administrators, and nurses usually spend four or five months in programs specially designed for them by the Institute staff, School faculty, and community agencies.

Professional and technical support by the faculty tend to be most effective in field interchange of field training activities in the Pacific islands. The experience, knowledge, and skills of the faculty are utilized by having appropriate faculty members on the field interchange training team. Such field support has taken place in Okinawa, Taiwan, Trust Territory of the Pacific Islands, American Samoa, and Western Samoa. The School expects to continue this kind of support to the Institute since it believes that effective planning, assistance, and evaluation of its input in overseas activities contribute to the narrowing of the gap of educational and technical training needs of the developing countries of the Pacific region.

FACULTY ACTIVITIES

Instruction. By applying for and receiving Federal training grants, the faculty is able to enrich its instructional programs, thus giving greater depth to the public health curriculum. Current training grants from non-State funds totalling over \$800,000 enable the faculty to strengthen the programs in health education, maternal and child health, mental retardation, health services administration, cardiovascular disease, epidemiology, population and family planning studies, water supply and pollution control, international health, and the Peace Corps programs of Micronesia and the Pacific-Asian areas. The training grants provide the opportunity for faculty to strengthen their areas of concentrated study by means of additional resources in

teaching or consultation, personnel, additional equipment, travel to the mainland U.S. or Pacific-Asian region to teach, exchange, or receive data in their special fields of interest. Training grants also provide an opportunity for some students to conduct their field work in places outside Hawaii and in settings similar to that which they plan to go into following graduation.

An interesting outcome of numerous exchanges between the School's faculty and their foreign counterparts has been a grant to the School by the China Medical Board of New York to enable exchanges of senior faculty members of the School with faculty members of public health training institutions in Asia. The period of individual exchanges may vary from one semester to a full year. It is hoped that the first exchange will take place in fall 1968.

Research. Eight research projects, involving a total grant of approximately \$175,000, are now conducted or supervised by the faculty. These are the Hawaii Heart Study, Cancer Study, Genetic and Epidemiologic Studies of Clubfoot, Diet and Nutriture Study, Kauai Pregnancy Study, Population Studies of Oral Discases, Studies in Fertility Measurement, and Hodgkin's Disease in Woodworkers. The total number of full-time researchers and clerical staff funded under research grants is about fifty. Because of a severe shortage of space, new research proposals are considered with great care, for many of the present research staff are now housed in off-campus facilities such as Leahi Hospital and Queen's Medical Center. The scattering of personnel evokes problems in case of communication and transportation, but despite these handicaps, studies have been progressing satisfactorily.

Community Service. The faculty's commitment to community service extends not only to the Hawaiian community but whenever feasible, to the Pacific areas. The School's largest community service grant is the Peace Corps Health Program of the Pacific and Asian Areas. Several faculty members provide professional and technical support to the Peace Corps in (1) identifying health activities and programs appropriate for inclusion in training of its volunteers, and (2) assisting in the implementation of in-country program activities. The countries currently involved are the Trust Territory of the Pacific Islands, Tonga, Western Samoa, Thailand, and Malaysia.

The School also provides the public health training needs for the Asian Training Center which prepares health workers for AID service in Vietnam and Laos; it plans to do a comprehensive health plan for the Trust Territory of the Pacific Islands; it is presently drafting a professional support contract with the Government of

Guam. Faculty members serve as active consultants to the East-West Center, Agency for International Development, International Labor Organization, Peace Corps, South Pacific Commission, and the World Health Organization.

Faculty members serve on various health and medical community organizations such as the State Commission on Aging, Health Facilities Planning Council of Hawaii, Regional Medical Program, Hawaii Vocational Rehabilitation Plan, and the Governor's Committees on Mental Health and Mental Retardation.

The School continues to collaborate with the East-West Center's Office of Conference Programs in planning for and implementing international conferences relating to health and medical matters. Examples of past conferences are the Cholera Research Symposium held January, 1965; Conference on Public Health Training and Education in Asian Countries held in June, 1965; and the Conference on Population Studies in July, 1967. A Toxic Micro-organism Conference is planned for fall, 1968, when participants mainly from the United States and Japan are expected.

The faculty of the School is also moving in the direction of providing more local community services. At present it is generally still working at becoming familiar on a grass-roots level with various community neighborhoods on Oahu and developing meaningful working relationships with such areas. Students have been actively engaged in the various community action programs by, for example, participating with residents in Palolo, assisting in an analysis of medical care needs in Kalihi, and working with mothers at the Nanakuli and Waimanalo Child Care Centers. When appropriate, reports have been submitted to the area community action programs. The Honolulu community action program, under which the thirteen community action programs operate, has asked the public health education unit of the School to evaluate its programs. This kind of request, in which the School is able to give services to the community, is gratifying, since the faculty and students, more often than not, receive opportunities for experiences provided by such agencies and not available in the classroom.

At present students have also been placed in field work in the Hawaii Council for Housing Action, Strong-Carter Dental Clinic, and the Susannah Wesley Community Center. Another faculty member is evaluating the effectiveness of lay manpower used in the Head Start program. It is hoped that the establishment of relationships with the many community agencies will lead to more abundant interchange of ideas and action between the faculty and the community health practitioners. ■

Procainamide should not be chosen for long-term therapy unless there is no acceptable alternative drug. Here's why.

Lupus-like Syndrome after Procainamide

B. R. MEHTA, M.D., Honolulu

● *Procainamide given to a 45-year-old man for control of persistently recurrent atrial fibrillation caused a syndrome indistinguishable from mild systemic lupus erythematosus. Symptoms subsided promptly on stopping the drug, but the LE cell test remained positive for at least three months.*

SINCE the first description by Ladd¹ of a syndrome closely resembling (if not identical with) systemic lupus erythematosus (SLE), occurring after the administration of procainamide, 28 more cases have been reported in the American literature and one case has been reported from Britain. This is a report of the 31st such case.

Many drugs have been implicated in production of this syndrome. Among them the drug most commonly involved has been hydralazine.² Other drugs rarely implicated are: sulfonamides, anti-convulsants, penicillin, phenylbutazone, tetracyclines, streptomycin, isoniazid, griseofulvin, thiouracil, procainamide, and recently the contraceptive pills.

CASE REPORT

A 45-year-old white man was seen for the first time on May 23, 1962, with a sudden episode of palpitation. He was found to have paroxysmal atrial fibrillation and was converted promptly by digitalization to a normal rhythm, but subsequently he had a number of similar episodes. In 1965 he was given quinidine sulfate, but as it did not control these attacks, he was changed in August, 1965, to procainamide 250 mg four times a day. He did very well on this regimen except for

one episode of supraventricular tachycardia on April 3, 1967.

In September, 1967, he started complaining of pains in the small joints of his hands. The metacarpophalangeal joint of the right index finger was particularly affected, and noted to be slightly swollen and tender. He also had fleeting pains involving the right hip. There were no other symptoms.

Physical examination was essentially negative except for the swelling of the index finger. The laboratory work-up, including complete blood count, sedimentation rate, latex agglutination for rheumatoid factor, uric acid, and BUN were all within normal limits. LE test was not done at this time. Subsequently he developed diarrhea due to *Salmonella* infection, and stopped taking procainamide. His joint pains disappeared.

On January 3, 1968, he had another episode of supraventricular tachycardia and resumed taking procainamide, 250 mg q.i.d. He promptly developed arthralgia, involving the same small joints of the hand. At this time an LE latex test for nucleoprotein antibodies was reported positive. Complete blood count, total protein, and A/G ratio were normal. The serum immunoelectrophoretic pattern was normal and no antinuclear bodies were seen. Procainamide was promptly discontinued; however, his joint pains persisted. He was treated with prednisone for two weeks with complete remission of his symptoms, and had no further joint pains. LE cell test and two slide agglutination tests performed two months later were still positive.

DISCUSSION

Paine³ in 1965 reviewed all the 12 cases re-

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ported up to that time, eight from the previous literature^{4, 5, 6} and four of his own. Carabia and Fortney,⁷ McDevitt and Glasgow,⁸ each subsequently reported a case. Fakhro, Ritchie, and Lown⁹ reported 15 cases of this syndrome in 50 of their patients who were on procainamide during a period of four years. Prockop¹⁰ reported the only case in which this syndrome was observed in a noncardiac patient with myotonia dystrophica, who was given procainamide for relief of muscle spasms.

In all the reported cases the commonest manifestations were polyarthralgia (26 cases), positive LE cell preparations (25 cases), pleuritic and respiratory symptoms (17 cases), and the presence of antinuclear factor (21 cases). The dose of procainamide varied from 0.5 gm to five gm a day. The time interval between the administration of drug and appearance of symptoms varied from three weeks to 22 months.

Our case received one gm of procainamide daily for a year before appearance of this syndrome. It was interesting, however, that second inadvertent exposure to the drug brought on the symptoms promptly. The latex slide agglutination was positive in two, negative in three, and equivocal in one of the previous reported cases. In our case both slide test and cell preparation were positive; however, antinuclear antibodies were not found. There have been reports of various other abnormal laboratory tests, but in this case they were all normal. In two reported cases attempts to demonstrate agglutination of procainamide-coated tanned cells failed to show antibodies.^{3, 5}

The mechanism of this drug-induced syndrome is still controversial. Some authors, including Alarcon Segovia² and Lee,¹¹ feel that the drug unmasks a predisposition to SLE. Studies of the hydralazine-induced syndrome have shown that symptoms and signs possibly due to SLE were present in some cases before the drug was given. Further patients who have at one time developed drug-induced SLE have occasionally been observed to have apparent spontaneous recurrence of the disease years later. But in all the reported cases of procainamide-induced SLE, no such case has been observed. Unlike the hydralazine reactors, none of these reported cases have suffered prolonged symptoms after the drug was withdrawn.

The other possible explanation offered is that this is a drug hypersensitivity phenomenon. In support of this is a case reported by Prockop,¹⁰ in which procainamide was given in a case with established SLE in full doses for 15 months for relief of myotonia, with no exacerbation of the

symptoms of the disease. This may mean that the drug-induced syndrome is different from the disease.

That this phenomenon could be just coincidental is refuted by the increasing number of cases reported in the literature. McDevitt,⁸ commenting on the paucity of such case reports in the British literature, explained that this was because procainamide was the choice of drug for atrial arrhythmias and ventricular ectopic rhythms in America, but not in Britain. Fakhro, Ritchie, and Lown divided their cases in three groups: (1) four asymptomatic patients, (2) five patients with abnormalities limited to joints, (3) six patients demonstrating the more classic syndrome of SLE. All of their patients had elevated titers of antinuclear antibodies and 11 had positive LE cell preparations.

The majority of the reported cases have shown prompt relief of symptoms after discontinuation of the drug. However, in some cases, due to persistent symptoms, corticoids were used, with prompt recovery. In this case, prednisone gave prompt relief in a short time. The reversion of LE test to negative after stopping the drug was reported in all but four cases. In two of these the LE test was still positive after seven and eight weeks and in the other two the manifestations of the syndrome lasted for a long time after discontinuation of procainamide. In our case the LE test has remained positive after 12 weeks; however, the patient has remained completely asymptomatic.

The apparent importance of long-term therapy with procainamide is stressed in genesis of this syndrome. When long-term treatment is envisioned, the risk of this syndrome should be considered, and an alternate, less potentially harmful drug should be chosen.

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REFERENCES

1. Ladd, Anthony G.: Procainamide induced lupus erythematosus, *New Eng. J. Med.* 276:1357-1358 (Dec. 27) 1962.
2. Alarcon Segovia, D., *et al.*: Lupus diathesis and hydralazine syndrome, *New Eng. J. Med.* 272:462-466 (March 4) 1965.
3. Paine, R.: Procainamide hydrochloride and lupus erythematosus, *J.A.M.A.* 194:23-26 (Oct. 4) 1965.
4. Hahn, Andrew L.: Systemic lupus erythematosus associated with procainamide therapy, *Missouri Med.* 61:19-23 (Jan.) 1964.
5. Coman, R. W., and Sturgil, B. C.: Lupus like syndrome induced by procainamide, *Arch. Intern. Med.* 115:214-216 (Feb.) 1965.
6. Kaplan, J. M., *et al.*: Lupus like illness and procainamide HCl, *J.A.M.A.* 192:444-447 (May 10) 1965.
7. Carabia, A. G., and Fortney, T. G.: Case report: lupus like syndrome with positive Hargrave phenomenon induced by Pronestyl, *etc. J. Tenn. Med. Ass.* 58:298-289 (Sept. 23) 1967.
8. McDevitt, D. G., and Glasgow, J. F. T.: Lupus like syndrome induced by procainamide, *Brit. Med. J.* Vol. 3, 780-781 (Sept. 23) 1967.
9. Fakhro, A. M., Ritchie, R. F., and Lown, Bernard: Lupus-like syndrome induced by procainamide, *Amer. J. of Cardiol.* Vol. 20, No. 3, 363-373 (Sept.) 1967.
10. Prockop, D.: Myotonia, procainamide and lupus-like erythematosus by drugs, *Arch. Neurol.* 14:326-330 (Mar.) 1966.
11. Lee, S. L., *et al.*: Activation of systemic lupus erythematosus by drugs, *Arch. Intern. Med.* 117:620 (May) 1966. ■

Beta-hemolytic streptococci are far likelier to be found in a child's throat if they're also present in skin lesions.

Isolation of Streptococci from Throat and Dermal Lesions

Study among Children in Hawaii

L. T. CHUN, M.D., and MARJORIE W. DOLE, M.S., *Kailua*

• *Children with pyogenic skin lesions proved to be nearly three times more likely to have Group A beta-hemolytic streptococci in their throats than children with respiratory infections, and over four times likelier than normal children. Streptococci were found twice as often in throat cultures if they were also present in the skin lesions, as when the skin lesions were negative. The converse was also true. The strains were similar in two-fifths of the isolations.*

RELATIVELY few studies have been done on the relationship between streptococcal infections of the throat and skin. Powers and Boisvert¹ in 1944 recovered group A beta-hemolytic streptococci from the rhinopharynx of 32 of 48 children with infected eczema. Markowitz *et al*² reported that 48 per cent of 303 children with superficial skin infections had bacteriologic serologic evidence compatible with recent streptococcal infection, and that among these 26.5 per cent had group A streptococci in nasopharyngeal cultures. More recently, Anthony *et al*³ reported that beta-hemolytic streptococci were recovered from 82 per cent of 270 skin cultures; 98 per cent of these were group A organisms. Among these patients with group A streptococci in skin lesions, 51 (24%) had positive throat cultures for the same organism. Group A streptococci apparently are not common inhabitants of normal skin.^{4, 5}

From a relatively large number of bacterial cultures from skin lesions and throats taken over a period of 16 months from August, 1961, through November, 1962, in semi-tropical Hawaii,

streptococci, often of the same type, were frequently identified from both sites. The results have been compared with those of a similar survey of the incidence of streptococci in the throats of children from Hawaii with and without evidence of respiratory disease.⁶

MATERIALS AND METHODS

Physicians in private practice and cooperating clinics obtained specimens for bacterial cultures from the skin and throats of 779 children, on the island of Oahu, who had skin lesions. Affected areas of skin were swabbed directly or after removal of scabs, and the swabs were inoculated from the pharyngeal and uvular areas. The swabs were moistened and suspended above the surface of Todd-Hewitt broth and stored at 4.0° C. until cultures were planted, after an average time of slightly less than 24 hours.

The swabs from skin lesions were streaked on and stabbed directly into sheep blood neopeptone agar plates. Those from the throat were agitated in the broth, pressed against the sides of the tubes, and then culture plates were inoculated similarly. An additional procedure was carried out with the throat culture material by making pour plates from the inoculated broth. After incubation, typical or suspicious colonies were subcultured, and bacitracin tests⁷ were used for tentative segregation of group A streptococci.

Group A strains were stored by the Frobisher sand desiccation technique, and typing was carried out later or verified by precipitin tests.^{8*} No attempt was made to subculture or identify organisms which did not grow aerobically or micro-

From the Kauaikeolani Children's Hospital and the University of Hawaii Medical School, Honolulu.
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* Typing sera provided through courtesy of the Laboratory Branch, Biological Reagents Section of the Communicable Disease Center.

TABLE 1.—Incidence of Group A Streptococci in Throat Cultures of Children.

SITE OF CULTURE	NO. OF CULTURES	GROUP A STREPTOCOCCUS, %	
		Throat	Skin
Skin and Throat— simultaneous cultures, when there were skin lesions.	779	22.4	44.7
DATA FROM PREVIOUS STUDY:			
Throat only— from unselected respiratory disease (no skin lesions).	5,667	8.4	N.D.*
Throat only— from healthy school children.	963	5.0	N.D.

aerobically on blood agar plates. Staphylococci were recovered alone or mixed with streptococci in 67 per cent of the skin cultures and were further characterized by their coagulase reactions.

RESULTS

The results are summarized in Table 1.

Throat cultures were positive for group A beta-hemolytic streptococci in 175 (22.4%) of 779 children with pustular or crusted skin lesions.

Of the 274 children with skin lesions who had infection of the upper respiratory tract, group A streptococci were recovered from 86 (31.4%) of throat cultures. From the 505 children who had no clinical evidence of infection of the upper respiratory tract, group A streptococci were isolated from 89 (17.6%) of throat cultures—a significantly lower frequency ($P<0.001$).

In children with or without respiratory symptoms or signs, throat cultures were positive for streptococci about twice as frequently among those who had streptococcal skin lesions as among those without such lesions ($P<0.001$). In the former group, there were 116 of 348 children (33.3%) and in the latter group without streptococcal skin lesions, there were 59 of 431 children (13.7%) who had group A streptococci isolated from throat cultures.

Group A beta-hemolytic streptococci were isolated from the skin lesions in 348 (44.7%) of the 779 children with such infections. In children from whom group A streptococci were recovered from the throats, simultaneous cultures from the skin lesions yielded streptococci in 116 of 175 instances (66.3%). Of 604 children in whom no streptococci were found in the throat cultures, only 232 (38.4%) had streptococci cultured from their skin lesions.

Of the 348 strains of streptococci isolated from the skin, all but two were group A; the two strains were not groupable. In a concomitant survey⁶ of throat cultures, we found group A streptococci in only 57 per cent of 997 strains of streptococci isolated.

No sex difference was noted in the rate of recovery of streptococci from the two culture sites. No significant seasonal variation was noted in the recovery rate of streptococci from throats of children with skin infections; a similar lack of seasonal pattern was also noted in those who had only respiratory symptoms.

The highest streptococcal recovery rate from throats occurred among 63 (43.4%) of 145 children, two through five years of age, with streptococcal skin infections. In our previous study of children with only respiratory symptoms, the peak incidence of streptococcal isolations was at a higher age level, six through 13 years of age.⁶ In children under two years of age who had streptococcal skin lesions, group A streptococci were recovered from the throats in 6 of 51 (11.7%), whereas none was isolated in this age group from the previously surveyed population who had only respiratory symptoms.

Forty pairs of streptococcal strains isolated from simultaneously cultured skin lesions and throats were typed by means of the precipitin test. By standards recommended by the Communicable Disease Center, nine of the 40 pairs (22.5%) had typing reactions which were alike, and seven (18%) were similar. In 22.5 per cent, however, the types were dissimilar and in 15 of the 40 pairs (37%) no typing reaction could be obtained. Four of nine pairs were classified as type 39; the others were identified as types 1, 8, 12, and 15.

Ten patients with acute rheumatic fever and 21 with acute glomerulonephritis were included in both this study of 779 children and from our previous survey of 5,667 throat cultures of children who had only respiratory symptoms.⁶ These diagnoses were known at the time the cultures were obtained. Pertinent information was obtained from a total of 1,073 questionnaires sent to physicians, who participated in both studies six to eight weeks after their patients were found to have had group A beta-hemolytic streptococcal infections. From 1,019 responses to the questionnaires, no additional poststreptococcal diseases were identified. Additional information revealed no antimicrobial agents were used in 23 per cent of the patients and five per cent received only topical medications.

DISCUSSION

The 44.7 per cent over-all positive culture rate of group A beta-hemolytic streptococci from a large number of common skin lesions demonstrates again that the streptococcus is a common cause—or invader—of skin lesions in this area. The incidence of streptococci in the skin lesions was twice as high when streptococci were found in the throat.

The frequency of positive cultures from throats (22.4%) was higher in children with skin lesions than in youngsters with acute respiratory disease (8.4%) and healthy school children (5%).⁶ When respiratory symptoms were present among patients with skin infections, the recovery rate of streptococci from throats was increased significantly.

Whether streptococci from skin lesions invade the throat or vice versa is not certain. We believe, however, that the former may be more likely, as skin infections were usually present before symptoms of respiratory disease appeared. Respiratory symptoms were of less than 48 hours duration in 86 per cent of the group, whereas skin lesions were present for more than one week in 31 per cent, two to seven days in 42 per cent, and for less than 48 hours in only 27 per cent, of the children.

That streptococcal infection of the throat and skin are associated is further attested by our finding that 40 per cent of paired streptococci had similar typing reactions. Virulence of streptococci is usually associated with M-protein production (which is a basis for their typing).⁹ Eighty per cent of strains isolated from the lesions, however, were nontypable, indicating that they were of low virulence. This fortunate circumstance probably helped account for the fact that no new overt poststreptococcal disease developed among this population other than those 31 who already showed evidence of poststreptococcal diseases at the time the cultures were taken.

Of interest was the variable rate at which streptococci were recovered from throats of children of different ages who had skin infections; this was highest among preschoolers, though streptococci were also recovered from infants under one year of age. In contrast, during a concomitant survey of respiratory infections, no streptococci were recovered from infants under two years of age. This higher incidence in the present series suggests that the association between the throat and skin infections in younger children may relate to such habits as finger sucking.

The frequency with which streptococci are recovered from skin lesions and the higher incidence of positive throat cultures among these children raise an important question: should streptococcal skin infections be treated with appropriate systemic antimicrobials? More long range studies need to be done on the frequency of all sequelae following streptococcal skin infections before such questions can be properly answered.

ACKNOWLEDGMENTS

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Association, the Department of Health—Bureau of Adult Health, Wyeth Laboratories, and the Straub Medical Research Institute of Hawaii.

The typing sera were supplied by the Communicable Disease Center.

The compilation and statistical analysis of data were done by Dr. Edwin Mookini of the University of Hawaii.

Specimens for culture were supplied by the outpatient departments of Kauaikeolani Children's Hospital, Queen's Medical Center, and U. S. Army Tripler General Hospital, and also by many physicians in private practice.

Much help and support for various aspects of the study were given by Drs. Warren Wheeler, Roger Cole, Morris Shaffer, Lewis Wannamaker, and the late Ralph Platou.

SUMMARY

Group A beta-hemolytic streptococci were recovered from throats of 22.4 per cent of 779 children who had pyogenic skin lesions. In a concomitant survey, streptococci were cultured from only 8.4 per cent of 5,667 children with respiratory infection and from five per cent of 963 healthy school children.

Group A streptococci were recovered from throats of children twice as frequently when the cultures from skin lesions were positive for streptococci as when they were negative.

The over-all positive culture rate of streptococci from skin lesions was 44.7 per cent. The incidence rose to 66.3 per cent when there was an associated isolation of streptococci from the throat but was only 38 per cent when there was no evidence of streptococci in the throat.

About 40 per cent of the streptococci obtained simultaneously from the skin and throat were similar strains.

30 Aulike St., Kailua 96734 (Dr. Chun).

REFERENCES

1. Powers, G. F., and Boisvert, P. L.: Age as a factor in streptococci, *J. Pediat.* 25:481 (Dec.) 1944.
2. Markowitz, M., Bruton, H. D., Kuttner, A. G., and Cluff, L. E.: The bacteriologic findings, streptococcal immune response and renal complications in children with impetigo, *Pediatrics* 35:393 (Mar.) 1965.
3. Anthony, B. F., Perlman, L. V., Wannamaker, L. W.: Skin infections and acute nephritis in American Indian children, *Pediatrics* 39:263-279 (Feb.) 1967.
4. Hare, R.: Hemolytic streptococci in normal people and carriers, *Lancet* 1 85-88 (Jan. 18) 1941.
5. Colebrook, L., Moxted, W. R., Johns, A. M.: Presence of hemolytic and other streptococci on human skin, *J. Path. Bact.* 41:521-527 (Nov.) 1935.
6. Chun, L. T., and Dole, M. W.: Streptococcal survey in Hawaii, *Hawaii Med. J.* 25:312-317 (Mar.-Apr.) 1966.
7. Moxted, W. R.: The use of bacitracin for identifying group A hemolytic streptococci, *J. Clin. Path.* 6:224-226 (Aug.) 1953.
8. Frobisher, M. J., Parsons, E. I., Pai, S. W., and Hakim, S.: A simplified method for the preservation of bacteria by desiccation in vacuo, *J. Lab. Clin. Med.* 32:1008 (Aug.) 1947.
9. Stillerman, G. H., Siegel, A. C., Johnsen, E. E.: Variable epidemiology of streptococcal disease and the changing pattern of rheumatic fever, *Mod. Conc. Cardio. Dis.*, 34, No. 10 (Oct.) 1965.

The President's Page



The last issue of the HAWAII MEDICAL JOURNAL for this year serves as a cruel reminder that this year of our Lord 1968 is almost over. It also reminds us that 1969 will soon come crashing down upon us.

I should like to bring to your attention the Annual Meeting of the Hawaii Medical Association. In 1969, it will be held from May 21 through May 24. And it will be held irrespective of what you may have heard to the contrary. The Hawaii County Medical Society and I admit that hotel room space in Hilo is at a premium and is woefully short. The big Rotary Club Convention in Honolulu at about this time has definitely not made easier the problem of hotel rooms in Hilo. And we have no fancy convention facilities. Rather, we have been obligated to use substitute facilities.

But if collective effort is an indication of prospective success, then I can assure you there will be no holding back this coming Annual Meeting. The local and Honolulu Arrangements Committees have been hard at work for quite some time.

The Hawaii County Medical Society will be at its gracious best and will try like the proverbial Hell to show you a good time. We'll even go as far as to guarantee no rain during the convention. The greens at our golf courses will be well groomed and as slick as the best that Honolulu courses can offer. Our liquor served here will be undiluted and we will try our darndest to couple that with pleasant surroundings and delightful company. But most of all, the program set up by our Scientific Program Committee for this Convention will be guaranteed to satisfy the most discriminating tastes and wants of our members.

So the Hawaii County Medical Society and I ask all members of the Hawaii Medical Association to mark the dates of our Annual Meeting and plan to live a full life with us over here in Hilo. We'll be expecting you—and we guarantee that you won't be sorry you came. HAWAII NO KA OI!

Robert W. Meyer

Shorter—or No—Isolation for Leprosy

"The longer I live," said Rene Dubos during a visit to Honolulu a few years ago, "the less I think the tubercle bacillus has to do with causing tuberculosis."

What he meant was that the really vital determinant of infection with this, as with most organisms, is less the availability of the germ than the susceptibility of the host. It was a paraphrase of Pasteur's "*Le bacille n'est rien; le milieu, c'est tout*:" the bacillus is nothing, the environment is all.

We can, and we should, be guided by this concept in deciding how to control leprosy in our community. Only about two per cent of our population—largely from families in which leprosy has occurred—are susceptible to it. And between a third and a half of those who do eventually catch it will be unaware of having had any contact at all with a patient, presumably because their exposure will have been so brief.

Children are many times more susceptible to infection than adults; if there are no children in the home, the risk is very slight, only a little greater than in the community as a whole.

Resistance can be supplemented by prophylactic chemotherapy with dapsone, given in small doses; and though this method suffers from the uncertainty inherent in long-term oral medication of any sort, parenteral depot therapy appears to be on the verge of becoming practical.

Risk of household exposure can therefore be substantially diminished, (1) by limiting it to adults, (2) by protection with chemotherapy, and (3) by converting lepromin-negative members of the family to lepromin-positive with BCG—though Skinsnes points out that this is relatively ineffective in Orientals.

In addition to all these possible modifications of Pasteur's all-important "*milieu*," Worth's studies in Hong Kong show that children exposed to lepromatous parents only after at least four months of sulfone therapy, at which time most of the bacilli in their tissues have become beaded or granular in smears, produces few or no new cases—none, within the seven- to ten-year period of

study so far completed. Mouse footpad inoculation studies show us, too, that there is a rapid, steep decline of infectivity of the bacilli during this period; thereafter, further decline is extremely gradual.

The first few months of therapy, therefore, probably yield almost complete protection against infection of exposed persons. The next five to 15 years of isolation and treatment, on which our law formerly insisted—or the next two to five years of it, which our present, more liberal law requires—add only slight further protection against transmission of the disease.

Moreover, as Olaf Skinsnes points out, exposure of the family has been going on ever since the patient's infection became manifest, some months before. It doesn't begin with the making of the diagnosis, and it's too late to prevent it. In fact, at this point the patient's contagiousness will start to diminish quite rapidly.

All that the diagnosis does, as Skinsnes says, is to introduce the doctor's conscience into the picture. This is no reason for sudden alarm and forcible isolation. It does warrant interdiction of nonhousehold exposure, of course, unimportant though this is. Whether any isolation at all is desirable, other than a brief period of confinement to the house, is open to serious question.

The contrast between the minute risk that so liberal a program might permit a few early, manageable cases of leprosy to occur in known contacts, and the certainty that lives will be disrupted, and patients' characters warped, by arbitrary isolation for a year, or several, is shocking to contemplate. It admits, we believe, of but one reasonable and humane conclusion: to isolate and treat most patients only in their own homes, for a few months, and to take such other precautions as are feasible to further reduce the possibility of infection of others during this period.

We need not—we dare not—insist on proof that infection of others could not occur under such a system. It could occur, though the increase of risk over that incurred under our present rules would be slight. But it would be well worth it!

Worst Foot Forward

Dr. F. J. L. ("Bing") Blasingame, the Texas surgeon who left his practice some 11 years ago to become the chief executive officer of the American Medical Association, was summarily fired by the AMA's Board of Trustees last September, without public explanation. His current five-year contract had four years to run.

This is the second recent symptom of a sort of group incapacity of the Board of Trustees; the first was the resignation, offered last year and then withdrawn, of the Board's then Chairman, Wesley Hall, of Reno. It was rumored that this was the result of a confrontation between a "liberal" and a "conservative" faction of the Board, which could not resolve their differences.

Dr. Blasingame's dismissal was announced to the public so clumsily as to arouse sharp criticism from Morris Fishbein in his editorial in the October 4 issue of *Medical World News*.

Now comes the AMA *Delegates' Handbook* for the winter meeting of the Association in Miami December 1-5—and though Dr. Ernest Howard is listed as "Acting Executive Vice-president," there is not even any mention of Dr. Blasingame's dismissal, let alone an explanation of it.

The AMA's trustees are fine, capable, public-spirited men, doing their job at a great personal sacrifice of money and time from their practices and their home lives. They must have had a compelling reason for their action. They are now on the point of having a management consultant firm advise them on how the AMA ought to be administering its affairs, which suggests at the worst a highly appropriate degree of humility—and at the best, a chance for the dawn of a new and brighter day for organized medicine in the U.S.A.

In Hemianopsia

Patients with left homonymous hemianopsia have no special problem with reading; the words run from their scotomas off toward the functioning right-hand visual fields, and they are able to read quite well. Reading for patients with right-sided hemianopsia, however, is a real problem, since the words are constantly vanishing into the areas of the scotomas.

Ophthalmologists have often tried to alleviate this by the ingenious expedient of fitting the patient with reversing prisms to make the print run from right to left, and with practice, they

are able to learn to read in this way, away from their scotomas, with fair success.

Comes now our Koolau colleague, Herman Kramer, M.D., to report an old and probably thoroughly forgotten trick through which these patients can circumvent the ophthalmologist and his prism glasses. It is simply this: to turn their book upside down, and learn to read the inverted printing. With a little practice, they can become very expert at this, and their problem is solved.

That's why we printed the title of this editorial the way we did.

New Features

With this issue we resume one old feature, under new authorship, and inaugurate one new one.

The old one is *This Is What's New*, formerly written by Fred Gilbert, now from the jumpin' typewriter of Philip Jones, former Chief Medical Resident at Queen's Medical Center, now at The

Center for Health Sciences of UCLA in Los Angeles, and soon to return to Honolulu to practice.

The new one is an instructive case for radiologic diagnosis, sponsored by the Radiological Society of Hawaii and written by various members of the Society.



Hawaii Academy of General Practice

The relative apathy in the recent political campaign was probably a consequence of the lack of major divisive issues. Concomitantly, there was no outstandingly prominent national leader to run for President of the United States—the candidates were all equally acceptable, or equally of no great attraction to the people, depending on whether you were a voter or a nonvoter.

As an example, the “issue” of Law and Order was not really an issue. All three major candidates were in favor of it (who can argue against motherhood?). Little was said and neither major candidate took any specific stand about the why of the so-called issue. It was a matter of an alarming increase in the rate of crime. It was a matter of dissent that was going beyond the bounds of reason and freedom of speech into the realm of destructive anarchy, revolution, and intolerance. These were obvious. All parties stated they would favor more laws, more restrictions, larger police forces—in other words, curtail the liberty of individuals as to freedom of assembly and freedom of expression. The courts were accused of an excess of permissiveness, setting an example for the granting of license to criminals to try harder at crime, license to communists and other enemies of the country to spread their evil influences, protected; and license to students and dropouts to disrupt the old ways of our society as they saw fit.

The underlying *raison d'être* has mostly been missed, however.

It is the laws themselves, the many laws-upon-laws, the rules and regulations, the interpretations and the directives, the implementations of these laws that have brought about this nationwide recalcitrance, which, indeed, may very well point toward a new revolution in America.

The relevance to our profession of medicine concerns MEDICARE and its Federal extensions.

The American Medical Association, representing by and large most of the physicians in the United States, was not opposed to the principle of a medical care program for the aged. As the population of oldsters reached some 17,000,000, it was understood by everyone that some national scheme must be devised to provide the kind of extended care that the elderly would be needing in view of our capacity to prolong life, even after “death.” What the organized profession didn’t like about MEDICARE, as it came out of a socialist-minded

Congress, was that what it offered was taken by most citizens to mean comprehensive care as long as medically necessary. Our AMA didn’t like the “politicians’ promise” that this country could easily afford to do this for *every* person 65 or older, rich and poor alike.

It has now become more than obvious that the “promise” cannot be kept; ours is not *that* affluent a country. A limited benefit—90 days in a general hospital, plus 120 days in a nursing home for recuperation and convalescence—is a cruel mirage when these benefits are curtailed or cut off by fiat from Baltimore!

Those of us involved in medical care at extended care facilities in Hawaii have had recent occasion to stand aghast at what Baltimore has been able to do to the people, surreptitiously, without their general awareness or knowledge; only the victims—the families concerned about the care of their oldsters—have borne the crushing blows so far. Many of them are too weak and too “little” to rise up and fight for justice that is being denied them. We need the spotlight of the press to focus on what is going on.

The facts of the matter are that the Federal government, through HEW in Baltimore, has been forced to admit that the costs of MEDICARE are even higher than the original detractors of the unwise legislation prophesied. HEW has discovered that physicians, in general, are the friends and protectors of their patients, that physicians tend to favor the oldster who is slow in recovering from serious illness or surgery, by keeping him a little longer in a general hospital bed. HEW has also discovered that even the lack of adequate extended care facilities initially has not prevented usage that is neither “over” nor an “abuse of.” HEW’S best laid plans to clamp curbs on usage via Utilization Review Committees have not stemmed the tide.

The very latest addition to the implementation of “Law and Order,” then, is one that will needle the people even more toward revolution: Months after an oldster goes home, in spite of meticulous and tedious URC work, Baltimore is denying the benefits of extended care. The family *must* fork out payment of not only a large, but a totally unbudgeted hospital bill in reimbursement! ■

J. I. FREDERICK REPPUN, M.D.

Sore Belly with Bruit

Compression of the celiac artery by the median arcuate ligament of the diaphragm can produce abdominal symptoms, says Dr. Lord of San Francisco (*Lancet*, Oct. 12, 1968). This condition usually affects middle-aged women who present with **upper abdominal pain**. The only constant physical finding is an epigastric bruit. Aortography shows typical anterior indentation of the celiac artery. Treatment is by division of the constricting band and in some cases arterial reconstruction.

Comment—Awareness of this syndrome may prevent a label of hypochondriasis being applied to an occasional menopausal woman with vague abdominal complaints, particularly when associated with a bruit. However, it must be remembered that some authorities doubt the validity of such a syndrome; compression of the celiac artery may be merely an incidental arteriographic finding and asymptomatic compression may occur.

College Football—A Transatlantic View

"Every Saturday, throughout autumn and early winter, American institutions of learning indulge in one of their most puzzling social rituals—the **Big Football Game**. The contest is staged in a large space resembling a Roman amphitheatre and usually referred to as a bowl of some sort—e.g., Sugar Bowl, Rose Bowl, but as yet the most fitting name, Vomit Bowl, has not been used. As a prelude to the gladiatorial contest, two or three bands hobble up and down the greensward, always out of step and often out of tune, pouring forth an evocative effluent of maudlin sentiment. Meanwhile, as a counter-attraction, a bevy of nubile nymphs in abbreviated skirts cavort and prance before the assembled multitude, twirling their canes, serpents, and other suggestive symbols. If the weather is a bit nippy and the spectator is lucky enough to have a ringside seat, it is possible to see cutis anserina develop on the vasti mediales of these latter-day vestal virgins. For good measure an octet of virile acrobats emerge from the bowels of the earth and, with prodigious leaps and lascivious writhing movements, exhort the spectators to join them in their arcane cheers. As the cheerleaders reach their orgiastic climax, a burst of borborygni-like sounds emanates from the bands as the musicians squeeze every last drop of breath into their instruments for their final flatulent fanfare" (*Lancet*, Aug. 24, 1968).

Arthritis and Promiscuity

Social change brings about change in social diseases. An apt illustration is **gonococcal arthritis** which once predominantly affected males and often led to residual joint disability. Now it occurs principally in young women and with adequate treatment leaves no residual joint disability. Diagnosis is made in the presence of acute arthritis with demonstration of gonococci in the blood or joint fluid, or the presence of gonococci in genital or skin lesions with definite improvement in the arthritis after appropriate antibiotic therapy. Treatment is usually with penicillin, though occasionally other antibiotics may be used. (Keisen, H., *et al*: Clinical Forms of Gonococcal Arthritis, *New Eng. J. Med.* 279:234, 1968).

Comment—Increasing promiscuity among teenagers and young adults must alert the clinician to the possibility of gonococcal arthritis. Confusion with **acute rheumatic fever** may easily occur if blood and joint fluid are not cultured.

Another not too uncommon situation is the young girl with **systemic lupus**. Following treatment with steroids, she feels well, and, while indulging in the normal pursuits of adolescence, may contract gonorrhea with arthritis. Her unsuspecting physician naturally attributes the arthritis to an exacerbation of the lupus and increases the steroids without undertaking any further studies. If embarrassment and possibly tragedy are to be avoided, be suspicious and get cultures!

Quotable and Controversial

Dr. John Todd pens a refreshing if somewhat iconoclastic essay on the "Cost and Complexity of Medicine" (*Lancet*, Oct. 12, 1968). Some pithy excerpts—"Excessive investigation in hospitals is common, many outpatient visits are unnecessary, and nearly all routine medical checks are of insignificant value, and may cause needless anxiety." On **regular medical checks**: "Even if health checks in future are found to be useful, which seems unlikely, the benefit they will yield will surely be minute by comparison with the benefit which anyone can obtain by **not smoking** and **not becoming fat**. The executive who smokes 50 cigarettes a day and is x-rayed every three months to catch his cancer 'early' provides an apt illustration of modern folly." ■

W. PHILIP JONES, M.D.

This is the seventy-fifth installment of In Memoriam—Doctors of Hawaii.

Lyman S. Thompson

Dr. Lyman S. Thompson, with his wife, Rachel, and his daughter arrived in Honolulu aboard the S.S. "City of San Francisco" on April 11, 1876. He was a native of Maine but other than that nothing is known about him prior to 1876. He was licensed to practice medicine in the Kingdom on April 21, 1876.

By June of that year the doctor was at Kohala, Hawaii, and had entered into an agreement with Dr. Richard Oliver, Government Physician for Hawaii, to care for all of Dr. Oliver's government patients in the northern section of the island. It was not long before Dr. Thompson was very dissatisfied with this arrangement, feeling that he was badly overworked, even having to treat patients from Dr. Oliver's district, and very poorly paid. When Dr. Thompson learned that the Board of Health was considering dividing Hawaii into two areas with a government physician assigned to each section, he wrote to the Board that he had canceled his agreement with Dr. Oliver and was interested in being appointed to one of the positions. On the next boat came a letter to the Board from Dr. Oliver stating that on June 1, 1876, Dr. Thompson had signed a twelve-month contract with him and could not therefore accept any other appointment without Dr. Oliver's consent.

However, by April, 1877, all difficulties between the two had been ironed out, and Dr. Oliver in a letter to the Board of Health tendered his resignation and recommended that Dr. Thompson be appointed his successor. He also informed the Board that Dr. Thompson had purchased his private practice, and very possibly this accounts for the cessation of hostilities. In any case, the Board of Health offered Dr. Thompson the position as government physician for the Kohala, Waimea, and Hamakua sections of Hawaii at a salary of \$800 a year and an allowance for medicines, and the offer was accepted in May, 1877.

On April 18, 1879, Mrs. Thompson died of consumption in Honolulu. Very shortly thereafter Dr. Thompson took his daughter to the mainland where arrangements were made for her care.

From the very first Dr. Thompson had been interested in the agricultural possibilities on Hawaii, and on November 1, 1879, he and Dr. Thomas P. Tisdale of Honolulu joined together to lease the Halawa Sugar Company for five years. In that same month planters and mill owners in the Kohala district met and formed an association of which Dr. Thompson was elected vice-president.

In 1881 he took a trip back East and broke into print in a Boston newspaper when he indignantly denied a story reprinted from the *San Francisco Chronicle* about "the hideous forms of slavery introduced in the Sandwich Islands under the pretext of importation of laborers."

In the following year at a ceremony described as a brilliant affair, Dr. Thompson married a Miss Kimball at Kohala on June 22. A son, Lambert M., was born to them.

The doctor was appointed port physician for Mahukona by the Board of Health in August, 1882. In December of that year he was elected president of the newly organized Kohala Social Club, whose aim was announced as the giving of select entertainments and encouraging a good time. By April, 1883, the doctor was heading the building committee for the Episcopal Church and construction was about to begin. About this time Dr. Thompson's Drug Store is mentioned, but it seems to have been sold in 1884.

In 1886 a petition asking for Dr. Thompson's dismissal as a government physician for North and South Kohala was sent to the Legislature. The doctor was criticized as being busier as a sugar planter and lawyer than in practicing medicine, and one of the legislators characterized him as a gossip and called him unpopular with the natives. In his defense a petition was presented to the Legislature which bore the signatures of 325 Hawaiians, 300 Chinese, and 109 Portuguese, and asked that he be retained as government physician. He seems to have ridden out the storm, but in August, 1887, the Board of Health asked for his resignation.

The following month Dr. Thompson left Hilo aboard the brigantine "Lurline," bound for California. His destination was Los Angeles, where he took charge of the smallpox hospital during a serious epidemic, and, subsequently, made a repu-

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University of Hawaii

Recently appointed members of the faculty in the Section of Surgery are **Ralph B. Cloward, M.D.**, Associate Clinical Professor of Neurosurgery; **Marvin Cressman, M.D.**, Assistant Clinical Professor of Neurosurgery; **William Burkhalter, M.D.**, Assistant Clinical Professor of Orthopedies; **Andrew L. Morgan, M.D.**, Assistant Clinical Professor of Urology; **Thomas G. Nelson, M.D.**, Assistant Clinical Professor of Surgery; and **John F. Chalmers, M.D.**, Clinical Instructor in Surgery. Recent promotions in the Section of Surgery are **Verne C. Waite, M.D.**, **Thomas Whelan, M.D.**, and **Frank McDowell, M.D.**, to Clinical Professor; **Gilbert C. Freeman, M.D.**, and **Lawrence H. Gordon, M.D.**, to Associate Clinical Professor. In September **Richard T. Mamiya, M.D.**, attended the annual meeting of the Transplantation Society in New York.

New appointments in the Department of Pathology were **Lawrence J. McCarthy, M.D.**, **Young K. Paik, M.D.**, and **Hideo Namiki, M.D.**, Assistant Clinical Professors; and **Joseph Plumbo, D.D.S.**, Clinical Instructor. **Olaf Skinsnes, M.D., Ph.D.**, attended the 4th Pan Pacific Rehabilitation Conference in Hong Kong, September 1-7, the Leprosy Workshop in London, September 13-14, and, accompanied by **Hong-Yi Yang, M.D.**, the 9th Leprosy Congress in London, September 16-21, 1968.

In the Section of Psychiatry, **Walter F. Char, M.D.**, attended the annual meeting of Professors of Psychiatry, Western Region, in Denver, Colorado, September 5-7. On September 17 **George F. Solomon, M.D.**, Assistant Professor of Psychiatry, Stanford University, and Chief, Psychiatry Training and Research Section, Veterans Administration Hospital, Palo Alto, visited the U. H. School of Medicine and various State agencies concerned with mental health.

Merle Ansberry, Ph.D., Chairman of The Division of Speech Pathology and Audiology, is currently on sabbatical leave during research in Audiology in several schools in the mainland. **E. Gene Ritter, Ph.D.**, recently traveled to Guam to assist the Territorial Department of Health improve its program in speech and hearing.

In September the Board of Regents approved the establishment of a management committee for Leahi Hospital to be effective January 1, 1969.

Maurice L. Brodsky, M.D., Executive Director and Administrator of Leahi Hospital, will act as Staff advisor to the Committee. Members are: Dean, School of Medicine (Chairman), **W. C. Cutting, M.D.**; Dean, School of Public Health, **R. K. C. Lee, M.D.**; Dean, School of Nursing, **M. S. Dunlap, Ph.D.**; Vice President for Business Affairs, **Mr. R. S. Takasaki**; Chiefs of Service, Surgery, **Richard T. Mamiya, M.D.**; Medicine, **Richard K. Blaisdell, M.D.**; Pediatrics, **H. C. Shirkey, M.D.**; Psychiatry, **W. F. Char, M.D.**; Obstetrics-Gynecology; **R. W. Noyes, M.D.**; Pathology, **E. T. Nishimura, M.D.**; Representative of the Preclinical Sciences, **T. A. Rogers, Ph.D.**

In spite of record heat, the Health Fair was a great success, and the University of Hawaii was proud to be a part of this endeavor. The Department of Pathology displayed human and animal tumors and, in a separate exhibit, part of Olaf Skinsnes' beautiful collection of art and History in Oriental Medicine. Anatomy showed material on hormone control of sex behavior, and on fertilization and implantation of ova. Biophysics had models of an electron spin diagnostic instrument for experimental cancer detection, and Comparative Medicine portrayed the role of laboratory animals in medical research. Speech Pathology showed material on hearing and speech rehabilitation. The Department of Nutrition, College of Agriculture, displayed the most obese rat ever, farther out even than Barnum and Bailey. The Pacific Biomedical Research Center demonstrated energy expenditure, and the Department of Educational Psychology showed material on the mental health of exceptional children. The School of Public Health had an elaborate display on the population problem. Medical students in the second-year class participated in many of these exhibits and manned the HMA "Career in Medicine" booth whenever they were not in class. U. H. is looking forward to the next Health Fair.

After months of delay, the Department of Anatomy has finally had two NIH grants approved and funded. **V. J. De Feo, Ph.D.**, is principal investigator of an electron microscopie and histochemical study of the decidualization process of ovum implantation (\$35,793 for year-1, with four

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**Heredity, Disease, and Man:
Genetics in Medicine**

By Alan E. H. Emery, M.D., M.Sc., Ph.D., M.R.C.P.E.,
247 pp., \$6.95, University of California Press, 1968.

IN WRITING THIS BOOK, Dr. Emery has followed his Editor's policy to a tee. The result is a book which is not very useful to practicing physicians since it is so very general. I cannot envision a physician using this in his office practice, although he might feel that reading this book would be a good way of bringing himself up to date with some of the concepts of genetics and heredity. After reading this book he would probably be on par with our University graduates who have had to take a course in biology and genetics.

SORRELL H. WAXMAN, M.D.

**Hereditary Disorders of Erythrocyte
Metabolism**

Proceedings of the Symposium held February 13-15, 1967, at the City of Hope Medical Center, Duarte, California.

Edited by Ernest Bentler, M.D., 343 pp., \$9.00, Grune & Stratton, 1968.

THIS IS A COMPILATION AND DISCUSSIONS of the papers presented at a symposium on genetically determined abnormalities of red cell metabolism held February 13-15, 1967, at the City of Hope Medical Center, Duarte, California. Each lecture is a review of current information plus new data and information. The discussions which follow are highly informative and interesting. For those interested in the defects of the red cell metabolism, these proceedings offer a vast amount of knowledge much of which is new data.

ROBERT T. S. JIM, M.D.

Progress in Learning Disabilities, Vol. I

Edited by Helmer R. Myklebust, 273 pp., \$12.50, Grune & Stratton, 1968.

THIS VOLUME OF TEN PAPERS by a wide variety of well-known specialists in virtually all of the disciplines associated with "minimal cerebral dysfunction and specific learning disabilities," represents a significant and very worthwhile effort to provide interested professionals with a sound, over-all view of the current status of work in this general area. As such, it is definitely a volume of "required reading" for clinician and researcher alike, although each will find some major sources of dissatisfaction.

The quality of the individual papers is uneven, with regard to both content and readability, and there are some striking omissions. For example, while Dr. Myklebust's "Definition and Over-View" is excellent, the chapter on "Pediatric Neurology" by Dr. Vuckovich says little about this specific area and seems more an attempt at a condensed handbook of general pediatric neurology. Dr. Ames gives excellent case presentations, but far too many, and too few over-all statistical data to support her developmental hypothesis. While Dr. Frostig is extremely helpful and innovative in terms of "what to do" with the MCD-LD child, it is most regrettable that neither she nor anyone else has devoted significant space to a review of the psychological test data in terms of utility

in diagnosis and prediction for treatment. This seems to be treated too matter-of-factly, as if all needed progress in this area had already been made and was in widespread use and professional agreement.

All of these drawbacks are of consequence, but even the sum of them does not make this an unimportant book. Even after the first reading, it should be of continuing reference use.

JEROME I. BOYAR, Ph.D.

Treatment of Heart Disease in the Adult

By Ira Lloyd Rubin, M.D., F.A.C.P., F.A.C.C., Harry Gross, M.D., F.A.C.P., and Sidney R. Arbeit, M.D., F.A.C.C. *Clinical Pharmacology* by Duncan E. Hutcheon, M.D., D.Phil., (Pharm), 393 pp., \$17.50, Lea & Febiger, 1968.

THIS SMALL BOOK presumes accurate diagnosis. It is brief, yet not too sketchy, although in some chapters, as in new electronic methods and coronary care, this appears to be so.

An advantage to its style is that some information is quickly available and drug dosage and administration is specific and to the point. Its value lies in its brevity and clarity of print.

BERNARD J. B. YIM, M.D.

Surgery of the Aged and Debilitated Patient

Edited by John H. Powers, M.D., 611 pp., \$19.00, W. B. Saunders Company, 1968.

THIS BOOK has been designed to delineate the problems and complications of operating upon the aged patient. The introduction presents the growing impact of the "aged" in our population. Starting with the "physiologic deviations" associated with aging, subsequent chapters cover alterations in metabolism, anesthesia risk, resistance of organs and tissues to infection, etc. Surgery of various organ systems and finally cancer surgery plus surgical mortality in the senior citizens is presented. Throughout, there is a very strong emphasis on physiology, making this book interesting to all concerned with surgery on these patients.

ROY I. IRITANI, M.D.

Pathology Annual, Vol. 3

Edited by Sheldon C. Sommers, M.D., 466 pp., \$14.75, Appleton-Century-Crofts, 1968.

THIS IS THE THIRD volume in a relatively new series of yearly editions composed of essays on various subjects. The reports offer an excellent review and a source of the newer concepts of many disease entities, primarily from the pathologist's point of view. Unlike the Yearbook series, the Pathology Annuals do not attempt to cover the entire field with brief resumés, but concentrate on selected areas. In the present (1968) edition there are five articles concerning the kidney and three related to the lung. The six other chapters vary from amyloidosis to malaria in Vietnam. Although written for pathologists, most of the articles would be of interest and value to our clinical colleagues, and the book is recommended to all physicians.

ANN B. CATTS, M.D.

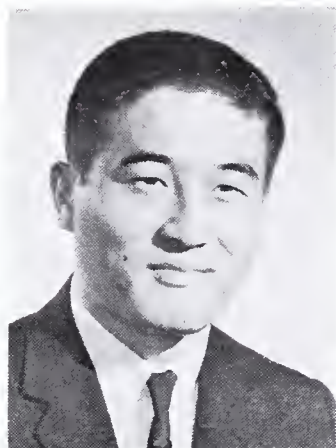


- This 60-year-old man has had a huge lump in his neck, and hoarseness, for an unknown length of time.
- The mass is firm, slightly mobile, and not tender, and measures about three inches in diameter.
- By laryngoscopy the tumor is smooth, submucosal, and nonulcerating. It occupies the entire left epiglottis and left aryepiglottic fold, and extends down to the true vocal cords.
- General health has been good, and the patient feels well.
- Roentgenograms show the mass destroying thyroid cartilage and elevating the hyoid.

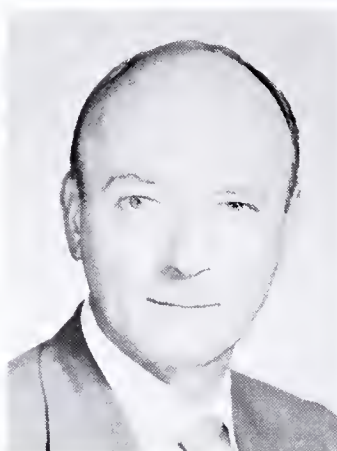
- What is your diagnosis?
- Answer is below.

Laryngeal tomography revealed erosion, displacement, compression, and sclerosis of thyroid cartilages by the spherical tumor, without evidence of invasion. Preoperative diagnosis was a slowly enlarging benign thyroglossal duct cyst. The cyst was dissected free intact and completely surgically excised without complication. Diagnosis confirmed by pathologist.

Submitted by the
RADIOLOGY SOCIETY OF HAWAII
ROBERT G. RIGLER, M.D.



Paul J. H. Matsumoto, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
GENERAL SURGERY
Tufts University School of Medicine—
1958
Internship—Carney Hospital,
Boston, Mass.—1958-59
Residency—Veterans Administration
Hospital, Buffalo, N.Y.—1961-66



Clyde Arthur Rossberg, M.D.
Kula Sanatorium
Kula, Maui 96790
GENERAL PRACTICE
University of Maryland Medical
School—1941
Internship—St. Agnes Hospital—
1941-42
Residency—St. Agnes Hospital—
1942-44



**Laurence James McCarthy,
M.D.**
888 South King Street
Honolulu, Hawaii 96813
PATHOLOGY
Harvard Medical School—1960
Internship—Boston City Hospital—
1960-61
Residency—Mayo Clinic, Rochester,
Minnesota—1961-65



Drake W. Will, M.D.
Queen's Medical Center
P. O. Box 861
Honolulu, Hawaii 96808
PATHOLOGY
UCLA School of Medicine—1956
Internship—UCLA Medical Center—
1956-57
Residency—UCLA Medical Center—
1957-60



Percival H. Y. Chee, M.D.
888 South King Street
Honolulu, Hawaii 96813
OPHTHALMOLOGY
University of Rochester School of
Medicine—1962
Internship—Travis AFB Hospital—
1962-63
Residency—University of Miami,
Miami, Florida—1965-68

County Society News

Honolulu



Walter K. W. Young, M.D.
1282 Queen Emma Street, Room 205
Honolulu, Hawaii 96813

OTOLARYNGOLOGY

Jefferson Medical College—1960
Internship—St. Luke's Hospital,
Bethlehem, Pa.—1960-61
Residency—St. Luke's Hospital,
Bethlehem, Pa.—1961-62
Graduate Hospital, Philadelphia—
1962-63
Upstate Medical Center, Syracuse,
N.Y.—1963-65



Kenneth B. McCollum, M.D.
P. O. Box 849
Wailuku, Maui 96793
ANESTHESIOLOGY

University of Texas Medical Branch—
1955
Internship—Madigan Army Hospital,
Tacoma, Wash.—1955-56
Residency—Brooke Army Hospital—
1957-58
University of Colorado Medical
Center—1959-60

The June 4 meeting was preceded with a film on "Utrine Cancer." New members Rose Kam Ling Wong, Donn R. Grininger, Virgil R. Jobe, and Bliss C. Shrapnel were welcomed into the Society. Reports were made by Dr. Richard Omura on the AMA's Second National Congress on Socio-Economics; by Dr. Wilbur Lummis on the Poverty March demands and HEW's reactions; by Dr. Fred Reppun on his participation as a member of a panel at the annual meeting of Hawaii Public Health Association which had as its theme "Community Ferment as Related to Public Health Workers"; and by Paul Tamura and Robert Chung on the Health Fair. Announcements were made calling the members' attention to Dr. James Grobe's talk on psychosomatic medicine; the AAGP's idea of establishing a Board for the General Practice of Medicine; a seminar sponsored by the Alcoholism Clinic; a lecture on Rheumatoid Arthritis by Dr. Ephraim P. Engleman; and a postconvention seminar of AAMSE. It was voted to assess the members \$40.00 each in order to meet the cash demands upon the Society during the next year or two.

Approximately 120 attended the September 3 meeting, including the following new members: Leon Comroe, Jules Comroe, Gilbert Sofio, Percival Chee, Drake Will, Laurence McCarthy, Charles Nugent, and Paul Matsu-moto. Plaques from the AMA for volunteer service were presented. Recipients were George Kennessey and Truett Bennett. The latter was not present. Dr. Edward Boone announced the launching of the Aloha Fund Drive. A moment of silence was observed by the membership in memory of Eldon R. Dykes and James T. Kuninobu. Mr. Thorson advised that additional doctors were needed at Fort DeRussy to work on a part-time basis. Reports were received from the Foundation for Medical Care, Bureau of Medical Economics, Medical Plaza, Hawaii Health Fair, and the newly formed ad hoc committee on Community Health Service.

Kauai

No meetings were held during July, August, and September. At the October 1 meeting Dr. Audrey Mertz spoke on the new mental health law and the care of alcoholics. A meeting scheduled by RMP for all physicians will be held at Poipu Beach Hotel. Correspondence included a letter from the Maui County Medical Society relative to their resolution on the practice of osteopathy and one from St. Francis Hospital's Tumor Board relative to an application to RMP. An informal poll on the latter favored such a project. It was voted to accept a transfer of \$2,000 from the State Board of Health to conduct a diabetes survey.

Maui

Five guests were present at the June 18 meeting, which was devoted primarily to reports of the delegates who attended the HMA convention. An objection was made to the unpublished OCHAMPUS fee schedule. HMSA negotiations were discussed. It was unanimously felt that the physicians are willing to cooperate with HMSA but see no further use in negotiations. It was voted that the resolution relative to the Medical Practice Act be referred to the Board of Governors for review. It was voted to admit as dues-paying members all licensed physicians, whether temporary or otherwise. It was voted that all members pay for their own meals and beverages at each of the Society meetings. A report from the Diabetes Committee was circulated and unanimously accepted. ■

Preliminary Report on the Annual HMA Convention

We were introduced by Chairman **Varian Sloan** to **Rudy Wipperman**, the burly, gregarious G.P. from Hilo who is handling the Hawaii end of our 1969 Convention. With 150 physicians expressing a desire to attend, Rudy proudly reported on having negotiated for 100 reservations (a difficult matter these days, we understand, for Hilo has been experiencing a 90 per cent hotel occupancy rate since direct flights from the mainland started). An ex-Guardsman, Wipperman has tentatively reserved the National Guard Armory for the meeting. Lee McCaslin asked if the Armory had air conditioning. Rudy replied, "There will be lots of breeze. You know how much hot air there is when doctors get together." Pat Godfrey was interested in exact dimensions. "Is this a scale drawing of the Armory?" he asked. Rudy's wistful reply was, "This was drawn according to scale by a doctor and you know how smart doctors are." He then had second thoughts and qualified, "But we shall recheck the measurements anyway. . . ." Someone else wanted to know if there were sufficient restrooms. "When 700 National Guardsmen can gather there at one time, there must be enough restrooms. Now down South, however, we would . . ." he started, but stopped short in time because ladies were present. . . . When pre-session breakfasts of rolls and coffee were suggested, Lee pointed out, "Some have complained in the past that this was nutritionally unbalanced." Rudy: "Tell them that most delegates [he himself is one] are unbalanced anyway." At this point, Rudy, who claims to be "just a country boy," had his favorite hayseed joke to tell. We learned further that the HMA banquet will be at Sun Sun Lau, noted for excellent Chinese cuisine. Sportsmen's Nite will be on Friday night after the Golf Tournament at Maunakea Golf Course where golfers will commute from Hilo by bus. The Fishing Tournament will be held on the individual islands and the participants can compete later with their tallest tales. The Annual HMA Tennis Tournament will be held in Honolulu as previously. And oh yes, the scientific session handled by **Livingston Wong** will be on cardiopulmonary diseases, with at least six well-known speakers participating. We were reminded, however, that with limited hotel reservations available, we should make our commitments early.

Personal Glimpses

During a Tissue Committee meeting at Children's, the case of a six-month-old infant with respiratory distress who had a tracheostomy performed was being discussed. Pediatrician **Joe Oren** made the point that very few tracheostomies were done in pediatrics, but GP **Fred Dodge** said, "In the practice of adultery, we do see more. . . ."

At the quarterly staff meeting, Credentials Committee Chairman **Henry Yim** was introducing new appointees to the staff. "Now will anesthesiologists Doctors **Mitsuo Hattori**, **Jon Pegg**, and **David Johnson** please stand, if present?" There was nary a stir. . . . Intoned Henry, "Guess they're all busy passing gas. . . ."

We learned that "Slamming" **Hideo Oshiro** had made a hole-in-one on the 2d hole at Kaanapali in July while playing with **Nobu Nakasone et al.** When pressed for the traditional round of free drinks, he confidently

promised a round at the Royal Lahaina anytime anyone is up there.

Venerable tennis champ **Yutaka Yoshida**, has been suffering from a debilitating tennis elbow for many months, but still takes on all comers. He stubbornly refused offers by "friends" to inject it and continues to play a grimacing game. Perhaps now is the time for us to avenge our honors, tainted so ignobly in the HMA tournament.

The Kaiser Medical Symposium

With Kuykendall Auditorium at the University filled to capacity, the Annual Kaiser Medical Center Symposium was off to an auspicious start. We were treated to a gourmet's delight buffet dinner of fried chicken, roast beef with mushroom sauce, shrimp tempura, sushi, and other international delicacies. **Clifford Keene**, President of Kaiser Foundation Hospitals, gave with the welcome spiel, and **Stanley Batkin** was MC. **Clifford Strachley** presented a joint paper with **Paul Matsumoto** on the *Surgery of Extra-Cranial Vessels*. He reported on 35 cases of transient ischemic attacks surgerized over the past five years for internal carotid artery obstruction, with 31 still living. The salvage percentage is better than DeBakey's but Clifford qualified their results with the philosophical remark: "Obviously the salubrious results will erode with time."

Hilde Groth, Ph.D., an attractive blonde in a blue miniskirt, with Zsa Zsa Gabor accent and charm, reported on the effects of auditory deprivation on the development of hearing in white rats. She and her collaborators, **Stanley Batkin**, **John Watson**, and **Merle Ausberry, Ph.D.**, showed that white rats deprived of sound from birth (in a soundproof tunnel in Diamond Head Crater) could not hear as well as rats raised in a normal environment. She also reported, "The rats staged a love-in. Frequently we weren't even sure who was studying whom." Of mice and men.

Robert Glaser, Dean of Stanford's School of Medicine, was the principal speaker and his topic was, *Medical Breakthroughs: Their Implications for Society*. His message was that advances in medicine have brought many great things, but we have to keep our eyes open for problems they evolve. In renal transplants, one of the problems was that the recipient is not always grateful enough to the donor (especially among twins), but in cardiac transplants, the problem was again different, since the donor cannot be thanked. "Along with the great life-saving possibilities of the heart transplant operation, there have come legal and moral questions for which we don't as yet have answers." In Texas, there was the dilemma when three assailants were being tried for the murder of a man whose heart was transplanted. The defense lawyer maintained that there was no murder because the heart was still alive. Robert Glaser feels that the synthesis of DNA opens the possibility of changing the genetic structure of our cells. Perhaps some day, we may be able to eliminate some of the tragic birth defects, but on the other hand we might create other, more lethal, defects. "The real test is whether we can learn to use all of the advances in medicine and at the same time avoid the problems."

Paul McCallin reported on the use of gamma globulin as prophylaxis for rubella-induced congenital anomalies. In Hawaii 60 per cent of pregnant women showed susceptibility to rubella, in contrast to the mainland average of 15 per cent. During the 1965 epidemic, 88 women

tested showed 43 were exposed to measles during the first eight weeks of pregnancy. These 43 were all given gamma globulin; none of them developed rubella, and none of the babies showed abnormalities.

John Severinghaus from the U C School of Medicine who spoke on *Clinical Tips from Mountain Tops*, hobbled to the podium with his left arm in a cast. John mixed humor and scientific facts to make a delightful scientific cocktail. He joked that "Henry Kaiser probably got in the cement business because he was a good mixer." His scientific pearls were as follows: (1) It takes 24 to 48 hours before the CNS acclimatizes to hypoxia. (2) Beware of individuals born in hypoxia (their carotid chemoreceptors fail to respond to hypoxia). (3) Spare the carotid bodies and their innervations in surgery. (4) Treat stroke patients with hyperventilation—not with CO₂. (5) For artificial ventilation of emphysema patients, give them Diamox.

We thank the Kaiser Foundation for a delightful, well spent evening.

Elected, Appointed, and Honored

We learned from **Morton E. Berk**, American College of Physicians Governor for Hawaii, that for the first time, one of the James D. Bruce traveling scholarships (an important and signal award of the American College of Physicians) was granted to a Hawaii doctor, **Ralph M. Beddow**. The award was made on April 4, 1968, at the 49th Annual Session of the American College of Physicians. Ralph spent six weeks with **Russel Fraser** in the endocrine unit of the Royal Postgraduate Medical School of England, which maintains a foremost position in investigations of acromegaly and diabetic retinopathy utilizing Yttrium-90 implants.

We also learned that **Edward Jim** has received the Olin Senior Fellowship in head and neck surgery from Memorial Hospital in New York. Ed left in October for his postgrad training.

Incidentally, **Mort Berk** is a man of many talents. He

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JAMES T. KUNINOBU

1901 - 1968

Sixty-seven years is relatively young in the life of a physician who actively engages in the practice of medicine, but Dr. James Kuninobu, felled by the proverbial cardiovascular disease, spent his last 55 days in the Coronary Care Unit of the Queen's Medical Center, where he succumbed on August 24. He had survived his first coronary attack in May, 1966, and was well on the way to recovery when it was necessary to enter the hospital in June, 1968, for the second time.

He was born in Kealia, Kauai, on August 9, 1901. Aside from one year when he attended the Okayama Elementary School in Japan, he was the product of the public school system in Hawaii. He took his premedical course at the University of Hawaii, where he is remembered for his amateur boxing and his prowess on the football teams. He finished at Loma Linda University School of Medicine in 1928, and completed his internship at the White Memorial Hospital, Los Angeles.

Both his father and mother were devout Christians, and he received invaluable training at home and at church. He is remembered by his friends for coining the phrase—"too young to volunteer in the first World War, too old to be drafted in the second World War,"—referring to himself. This did not deter him from serving the community in innumerable ways. He was attending the now famous lectures on trauma at the Mabel Smyth Auditorium on December 7, 1941, when he, together with other physicians, was abruptly called to serve day and night to care for the wounded.

He joined the Seventh Day Adventist Church in 1924, and through active participation he was instrumental in establishing the Honolulu Japanese Seventh Day Adventist Church. His friends marvel at his loyalty as a Bible class teacher who spent many hours in the preparation of his weekly lessons, year after year.

He had met and married Chiyono Ogata of Mountain View, California, during his internship in 1928. Their home on Thurston Avenue and their summer home in Hauula have been the scene of many get-togethers with their friends.

In 1930, he accepted a call as a medical missionary in Japan, where he served at the Tokyo Sanitarium and Hospital for one and a half years. In 1932, he felt the need for further medical train-

ing and so, by way of the Trans-Siberian Railway of the U.S.S.R., he crossed the continent and reached Vienna, Austria. Elected to the American Medical Association of Vienna, he remained for six months receiving the best available postgraduate work in surgery, gynecology, and obstetrics in Europe.

In 1933, counted among the first group of Nisci doctors, he opened his office for private practice in Honolulu. He was on the staff at Kuakini Hospital, St. Francis Hospital, Kapiolani Children's Hospital, Castle Memorial Hospital, Queen's Medical Center, and the Kapiolani Hospital. He actively participated in their staff meetings and building programs. He took in the postgraduate seminars and medical conventions regularly. His specialty was general practice, but his leaning was toward obstetrics and gynecology. He was a member of the AMA, Hawaii Medical Association, Honolulu Medical Society, and the Pan-Pacific Surgical Association. He gave his time freely for the betterment of medical care for over thirty-five years.

A man full of cheerfulness, sympathy, goodness, and hope, he was a dedicated man. His first loyalty was to God. His service as a deacon and the chairman of the building committee of the church is being keenly missed by the congregation. A contributor to the YMCA and the Boy Scout movement from childhood, he could always be counted upon as a friend. His second love was to help the young people. He had sacrificed his own interest in order to aid innumerable young people, many times anonymously, to further their education.

His enthusiasm and faithfulness to the local alumni chapter of the Loma Linda University has gained for him the name "Mister Loma Linda."

A devoted father and husband, he will be remembered with respect and affection by his patients, his friends, and his professional associates. He is survived by his wife, his son, Dr. Leonard Kuninobu, an ophthalmologist at Monterey Park, California, and a daughter, Mrs. Joseph Nozaki (Verna) who is the wife of a medical missionary in Asuncion, Paraguay. There are two grandsons.

The greatest tribute accorded him has been the large number of patients, whom he restored to health or delivered. They came to pay their last respects to their doctor.

TADAO HATA, M.D.

COUNCIL MEETING
October 23, 1968—6:00 P.M.
Oahu Country Club

PRESENT

Robert M. Miyamoto, presiding, Drs. Batten, Chinn, Fong, Iaconetti, Lowrey, Mills, Miyashiro, Moore, Sloan, and Wipperman (for D. Wm. Jones), plus Drs. Goto, Lee, Stephenson, Tom, Uehara, and Wakai, Mr. H. Tom Thorson, Mr. V. Thomas Rice, and Mrs. R. Varian Sloan, President of the HMA Woman's Auxiliary.

MINUTES

The minutes of March 27, 1968, meeting published in the May-June issue of the JOURNAL were approved as circulated.

COMMUNICATIONS REQUIRING ACTION

Letters of Resignation: (1) Richard T. Mamiya, M.D., wrote a letter resigning as chairman of the Bureau of Research and Planning.

ACTION:

It was voted that Dr. Mamiya's resignation be accepted.

There was considerable discussion about Dr. Mamiya's role on the Bureau of Planning and Research and it was noted that the Council elects the members to the Bureau and that the Chairman is appointed by the President. It was pointed out that even though Dr. Mamiya's resignation has been accepted by the Council that he remains on the Bureau as a member. Dr. Miyamoto proposed Dr. Ralph Beddow as Chairman of the Bureau.

ACTION:

It was voted that Dr. Beddow be appointed as Chairman of the Bureau of Research and Planning.

(2) John R. Stephenson, M.D., wrote a letter resigning as Commissioner of the Public Health Commission. He also noted in his letter that he would continue to serve as Commissioner until Dr. Miyamoto was able to find a replacement.

ACTION:

It was voted that Dr. Stephenson's resignation not be accepted until a replacement has been found for his position as Commissioner.

Two physicians were suggested, Drs. Gilbert Freeman and Felix Lafferty.

(3) Theodore T. Tomita, M.D., wrote a letter of resignation from the following: Chairman of the Commission on Legislation, Chairman of the Ad Hoc Search, Medical Care Plans, and National Legislation Committees, and as a member of the Negotiating and Nominating Committees.

ACTION:

It was voted to accept Dr. Tomita's resignation.

The following were proposed as chairmen for the following: Commission on Legislation, George Goto, M.D.; Medical Care Plans, John J. Lowrey, M.D.; National Legislation, Cesar DeJesus, M.D.; Ad Hoc Search, William E. Iaconetti, M.D.; Negotiating and Organization Subcommittee, no one was suggested; and Nominating, an elective position.

Letter from Arnold W. Siemsen, M.D.: A letter was received from Dr. Siemsen, Director of the St. Francis Hemodialysis Center asking for HMA endorsement of his project. Dr. Chinn reported that the HMA should give endorsement to this program because it is the only one of its kind in the State of Hawaii, and that this is a worthwhile project.

ACTION:

It was voted to have the HMA strongly endorse this program.

Letter from Jordan S. Popper, M.D.: A letter was received from Dr. Popper, Stroke Director, Hawaii Heart Association, requesting HMA endorsement of his project and assistance in securing an RMP grant for funds to include at least the educational programs within the unit and salaries for project director and assistant director (all on a part-time basis) to be selected from physicians in practice in this community, and RMP funding for the purchase of monitoring equipment which will cost \$3,500 to \$5,000 at present estimates for a 2-bed unit.

There was considerable discussion regarding this correspondence. Some members of the Council felt that they could not act on something which they have not had sufficient time to study. Other members questioned how this program would affect the Rehabilitation Center and asked if Dr. Frederick Shepard had any knowledge of the proposed program. Dr. Lowrey asked Council permission to call Dr. Shepard to find out how he felt about the program. Dr. Lowrey reported that Dr. Shepard stated that the Rehabilitation Center becomes involved with these stroke patients after they are released from acute care units. Dr. Shepard pointed out that the Stroke Advisory Committee just received this letter on October 18, and that no recommendations were made at that time.

ACTION:

It was voted that the HMA endorse this program.

Letter from Stephen Kreitzer re SAMA: Mr. Kreitzer's letter requested HMA support and an advertisement in the Medical School Year Book. The HMA holds a membership in SAMA and the Council is requested to vote on whether to buy advertising space in their publication.

ACTION:

It was voted to buy space in the publication of the Hawaii Chapter of the Student AMA.

UCLA Biomedical Library: A letter addressed to Dr. B. A. Richardson was received from Miss Louise Darling, Librarian of the Biomedical Library at UCLA, requesting endorsement of the UCLA Biomedical Library.

Dr. Batten commented on the significance of the arrangement.

ACTION:

It was voted to support the Biomedical Library at UCLA.

Biliary Atresia Study: A letter to Dr. Miyamoto was received from Dr. Walton K. T. Shim requesting HMA approval to conduct a biliary atresia study which would entail perusal of patients' charts.

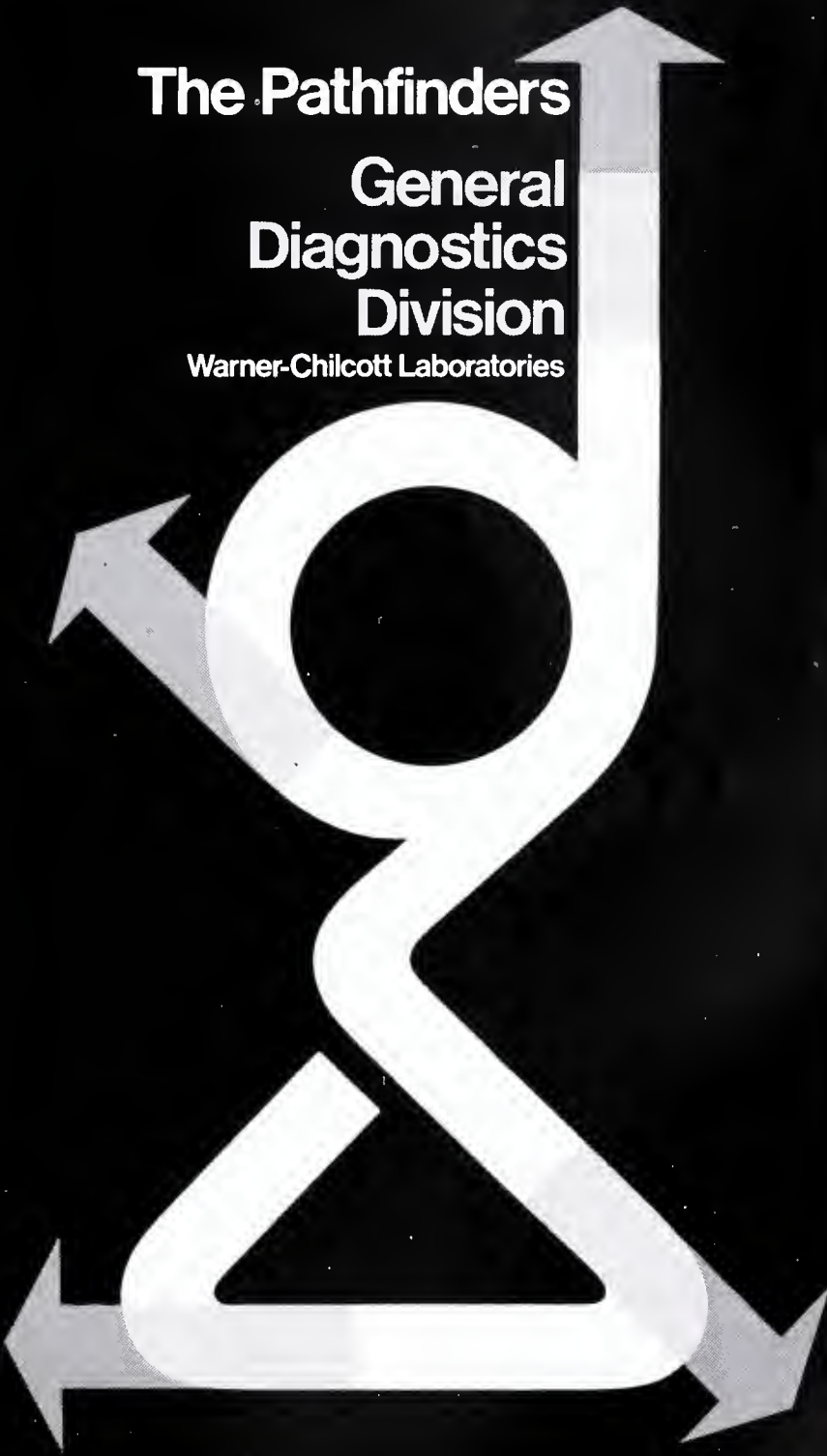
There was discussion on the previous request relative to a study on pyloric stenosis. It was noted that this matter was referred to the Bureau of Research and Planning and they felt that this was a worthwhile project and

continued page 160

The Pathfinders

**General
Diagnostics
Division**

Warner-Chilcott Laboratories



HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: EDITH G. EKSTEIN, MT(ASCP), U. S. Army Tripler General Hospital

Your Officers—1968-69

President, James Yano, MT(ASCP); *President-elect*, Elizabeth Hughes, MT(ASCP); *Recording Secretary*, Diane Ogasawara, MT(ASCP); *Corresponding Secretary*, Jeanne Otake, MT(ASCP); *Treasurer*, Noreen Kawamura, MT(ASCP); *Board of Directors*, Gilbert Gima, MT(ASCP); Ronald Miyakawa, MT(ASCP); Patricia Taylor, MT(ASCP).

Important Dates

- December 31, 1968—Deadline for submission of nominations for ASMT offices in 1969. This includes Regional Directors for the first time.

- May 15-18, 1969—HSMT Annual Meeting in Honolulu and Lahaina. Still tentative at press time, the Lahaina part of the meeting, if it materializes, will be HSMT's first conclave away from Oahu.

- June 22-27, 1969—ASMT Annual Meeting in Philadelphia. Dr. Seymour Wolfbein, Dean of the School of Business Administration at Temple University, will be Keynote Speaker on the subject of "The World of Work in the 1970's."

Immunology Addendum

Here are the details of the immunology course announced last month. The course will be presented by Dr. Albert Benedict, Chairman of the Department of Microbiology. Duration: January 6 to March 14, 1969. Time: Monday and Thursday evenings from 8:05 to 10:10 P.M. Tuition: \$48.00. Place: Edmondson Hall, Room 254. Credit hours: three. Further information: Education Chairman Norma Gavieres at Kaiser Medical Center.

For the Record

It is the responsibility of the officers and directors of a professional society to try to make their society an increasingly effective force in the community. Whether or not they succeed depends, in large part, on the participation of the membership which in turn can depend on the attitudes of the individual members. Too often criticism takes the form of silence—stay home, do nothing, say nothing. Nothing is less constructive than apathy.

The editors of these pages are trying to find out what medical technologists in Hawaii are thinking;

to find out if important ideas are being allowed to remain unexpressed. As a start we asked four questions of a representative group consisting of Mrs. Katherine Brown, Head Technologist at the Medical Group; SP-5 Barry Jones, an associate member who is a technician at Tripler Hospital; Miss Phyllis Sonoda, Assistant Chief Technologist at Queen's Medical Center; Paula Kim, Barbara Contratto, Audrey Liu, and Rosario Villacorte, interns at U.S. Tripler Army General Hospital who answered as a single person on a talk-the-loudest-and-fastest basis; and one MT(ASCP) who is not an HSMT member, and requested anonymity.

In what way could HSMT be made more meaningful to you?

MRS. BROWN: Workshops make a society attractive and are advantageous to the member.

SP-5 JONES: I think HSMT should base its plans on the inclusion of young members. The recent Health Fair, where all categories of the membership worked side by side with students and prospective members is a good example of the effectiveness of this idea. It demonstrates clearly that the organization is the common denominator of all groups. And publicity is important, too.

MISS SONODA: Work done by officers and committees should be publicized and reviewed periodically. New members would like to know what HSMT has accomplished and hopes to do.

STUDENTS: Provide educational programs directed toward us as well as toward the graduate. A very important function would be for HSMT to represent the members in things that affect them economically and professionally.

ANON: HSMT is more meaningful if you attend its meetings; but this is up to each individual.

What kind of meetings do you prefer?

SP-5 JONES: Meetings in which all can feel free to participate. I've noticed that the newer members seem too shy to speak up, almost as though they're afraid of the establishment. Recently someone suggested a separate subgroup of students with its own meetings and a representative on the HSMT Board. Maybe this would ease the transition period.

MISS SONODA: Dinner meetings occasionally. They seem more interesting and more sociable. There should be a hospitality committee at each meeting to seek out guests and new members.

STUDENTS: Meetings that are short and to the point are more apt to be interesting and stimulating than poorly controlled, long, and argumenta-

tive ones. And it helps to receive meeting notices well ahead of time. The notice should tell what the program will be or what subjects are to be brought up if it's a business meeting.

ANON: Dinner meetings are more interesting. But the interest must be in the member first. Then he'll attend any kind of meeting.

MRS. BROWN: Meetings that spend less time on the business and more on the technical part. Rotation of the places of meeting, centralized locations, would be helpful but are not as important as the subject and content of the meeting.

What type of services should an organization like HSMT provide for its members?

MISS SONODA: Salary surveys, establishment (and definition) of professionalism as a basis for bargaining. I don't think a union is the answer. Career days are fine but not enough; we need public relations via the media to get more exposure to the adult public. We need our own image, separate from the M.D. and other health careers.

STUDENTS: Educational programs; a listing of employment opportunities in Hawaii and in other areas also.

MRS. BROWN: Employment placement services. Members shouldn't have to pay agency fees. And better communication to keep vacancy listings updated.

SP-5 JONES: I think publicity is one of the most important things.

ANON: The Society should improve the image of the medical technologist among hospital personnel, including the medical profession. We could establish rapport with the nurses' organization for the improvement of patient care.

Did you read the August ASMT News?

MISS SONODA: Skimmed through for articles of interest. It might be interesting to discuss particular articles at meetings or to build a meeting around several articles.

STUDENTS: Yes. We all read just about all the literature that comes to us.

MRS. BROWN: I either read or scanned most of it.

SP-5 JONES: Yes, but I'm too new in the organization to really understand the importance of everything.

ANON: That issue was sent to former members with some other literature. I didn't read all of it even though I am considering rejoining HSMT.

Editorial

It was interesting and it was fun to hear the opinions of a few others who staff or study in our clinical laboratories. By asking a few nonecontroversial questions we collected some ideas which

might otherwise have remained forever unexpressed. Unexpressed ideas—silence—are just what every president wants least. So let's see what some of the suggestions would involve if translated into action.

First of all, we must express our gratitude to Anon., for suggesting that interest starts with the individual. We seem to have developed a habit of expecting our officers and program committee to create an interesting show for the rest of us while we sit in the audience in judgment. Then if we are not properly titillated, we stay away from subsequent meetings, fail to help on committees, or even drop memberships. Dues aren't supposed to buy amusement. They're the first recognition that you have interests that coincide with the interests of others.

Dinner meetings; early and descriptive meeting notices; workshops (to be prepared and presented by whom?); rotation of meeting sites and subgroups within HSMT are suggestions that our President and Board are happy to receive. Their ultimate decisions will, to a great extent, depend on the majority of *expressed* opinions. In other words, speak up!

Some of the answers which we received are not so easy to discuss. We're not sure what all the words really mean. "Professionalism," "image," "public relations," "publicity." Just exactly what should be publicized? What must we do to establish good public relations and with whom and why? Are we doing something wrong now or not enough that's right?

And why is a union not the "answer"? Do medical technologists have different employer-employee relationships than airline pilots or high school teachers? If so, is it because we are professionals? And just what is a professional? It seems to us that identification with a profession is the first characteristic of a professional and we don't think enough of Hawaii's medical technologists are so identified. Apparently, others don't think so either.

Now let's put some of our problem words together. Suppose for the sake of public relations HSMT sets out to project to the community an image—an image which describes the average professional medical technologist. Think carefully. Would you be fairly represented by an image of the average?

We refrained from asking one question very important to our publications committee: do you read the *Hawaii Technologists' Bulletin* in the HAWAII MEDICAL JOURNAL? If you do and if you've read this far, please let us know. Tell us what you think. ■

Maui In May—Plan Now

tation for himself when this hospital had the lowest death rate of any similar institution in the United States. He also conducted a successful drug business while in Los Angeles.

Returning to the Islands in April, 1890, Dr. Thompson went to Kona, Hawaii, as government physician for that district. Late in 1897 or early in 1898 he went back to Los Angeles, this time staying until August, 1899, when he returned to Hawaii again to accept a position as government physician at Kau. Here he practiced until the last day of December, 1903, when he left on a six-month tour through Europe and Asia. This proved to be so successful that it was followed the next year by a trip to the United States and the Bermudas. By 1911 the doctor had virtually given up his medical practice to devote all of his time to legal matters and his business interests, chief of which was the Thompson Association Settlement of Kau.

Dr. Thompson died on May 16, 1915, in Hilo at the age of 72.

During his years in Hawaii he held many positions, serving as a member of the School Board in 1887, inspector of elections in 1894, vice-president of the Kau Wine Company in 1903, and ran for district magistrate of Kau in 1906 but was defeated. He was a member of the Hawaii Territorial Medical Association. ■

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additional years recommended) and **R. W. Noyes, M.D.**, is investigator of a project on sperm transport in the female genital tract (\$45,751 for year-1, and 3 years of additional support). **Ryuzo Yanagimachi, Ph.D.**, presented some of his research on capacitation of spermatozoa (changes prerequisite for fertilization) at the first meeting of the Society for the Study of Reproduction at Vanderbilt University in September.

The Section of Obstetrics and Gynecology has participated in continuing education programs during the summer; **John M. Ohtani, M.D.**, and **John Duhring, M.D.**, panel on endometriosis, University of Southern California Postgraduate Program, August 22; **R. W. Noyes, M.D.**, Treatment of Menopause, American Academy of General Practice, September 24; **Theodore K. L. Tseu, M.D.**, and **R. W. Noyes, M.D.**, panel on fertility, International College of Surgeons, October 1. **Ralph Hale, M.D.**, has been appointed Clinical Instructor of Obstetrics and Gynecology.

After a tour of duty at the Central Hospital, Naha, Okinawa, **Lowell Wiese, M.D.**, has become Associate Professor of Pediatrics and Director of Kauikeolani Children's Hospital Outpatient Clinic. ■

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sired Honolulu's Olympian Brent Berk, of course; but in addition to this, a few years ago, he was runnerup in a National Kaiser Cookout Contest, and his recipe for Rolled Steak Hawaiian brought him a trip for two to the mainland, a jeepster station wagon, and other prizes. For those who are interested, the recipe for Rolled Steak Hawaiian is as follows: 1 lb. top round steak cut in two ¼ inch slices; 1 tbs. flour; one tsp. salt; ½ tsp. freshly ground pepper; 15 stuffed olives; 1 can mushrooms, drained and chopped; 1 can (5 oz.) water chestnuts sliced; 1 tbs. minced onions; ½ cup claret wine; ½ cup olive oil; 1 clove garlic, crushed; ⅛ tsp. oregano; ½ cup pineapple chunks, drained; foil. Mort also has a Pizza Hot Dog, modified. Those interested in the recipe should contact Mort. His comments on beef fall in the category of picturesque speech: "Obviously a good piece of beef is hard to beat anytime and a stuffing of this sort not only gives it some zing but it lends color which is lovely to behold. . . ."

We learned that our editor Harry L. Arnold, Jr., has been asked by Dorland's to review and edit their dermatologic definitions. We must also congratulate Honolulu physicians **Truett Bennett** and **George Kenessey** who were awarded the AMA certificate of humanitarian service at a recent Honolulu County Medical Society meeting. The awards were made in recognition of their participation in the AMA program of Volunteer Physicians for Vietnam. A **Shirley Tom** was chosen to receive the San Francisco Women Physicians Association's annual award, "The Outstanding Woman House Officer of 1967-68." Shirley, a Stanford Med School grad, returned to Stanford for an OB-GYN residency. Shirley apparently started as an RN and shifted to medicine to follow in the footsteps of her two older physician brothers, one of them being our own **Ben Tom**.

The Hawaii Chapter of the American Cancer Society

met in October at the Princess Kaiulani and awarded a citation to **George Mills**, who successfully directed their fund raising campaign to the tune of \$500,000. Its new officers include **Paul Tamura**, Chairman of the Executive Committee; **Cora Lee An**, Vice President; and **Clarence Chang**, treasurer. Incidental intelligence: The "Mark Waters Story," with Richard Boone portraying the title role, will be televised nationally very soon. The story, as you recall, is a Honolulu newspaper reporter's own poignant obituary, written in anticipation of his demise from lung cancer. The Oahu unit of the American Cancer Society met earlier in September and installed **Harold Bitner** President and **Clifford Strachley** Vice President. The feature speaker was **Robert Samp** of the University of Wisconsin who reported the apparent correlation of breast cancer to the lack of breast feeding. He also used the phrase, "Slobs beget slobs and smokers beget smokers" to emphasize that people, including even cancer society members, are reluctant to face up to the reality of what smoking does. There are too many who cannot understand and will not admit that it can and will happen to them. Board members of the Oahu unit include **Jerome Grossman**, **Robert Peyton**, and **Drake Will**.

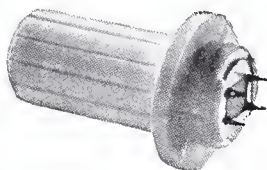
We congratulate **Bertram Weeks**, former chairman of the Maui County Unit of the Hawaii Heart Association, for receiving the Association's meritorious service award for 1967-68. Bertram helped organize the Eddie Tam Memorial Coronary Care Unit at Maui Memorial Hospital. The American Social Health Association (the only national voluntary health organization campaigning against drug abuse, VD, and prostitution), which is supported locally by the Aloha United Fund, has named **John Stephenson** as Honolulu volunteer representative. **Richard Moore** participated in a Medical Bowl TV program in San Francisco during the AMA convention. Richard scored highly, but the West team still lost the contest by a close margin.

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Professional Moves

In August, radiologist **George N. Takushi** and OB-GYN man **Charles B. Odom** associated with the Medical Group; another OB-GYN man, **Walter D. Vick**, associated with the Fronk Clinic, and neurologist **Raymond Chock** relocated to 1507 So. King. We also note a sudden influx of psychiatrists. **George Burnell** became chief of the Waipahu Mental Health Clinic; **Jacob Kahu**, who is in private practice in San Francisco, served as psychiatrist of the Kauai Mental Health Service from July 4 to August 26, until **Selius Guneyi** took over as chief. In September, psychiatrist **Henry K. Watanabe** opened his offices at 203 So. Vineyard and in Pearl City. On Maui, we see that general surgeon (and ex-colonel) **John Withers** joined the Maui Medical Group. Col. John received the Legion of Merit for organizing a mass casualty plan during the April Fool's Day raids on Victoria BOQ in Saigon in 1966. He chose Hawaii because scuba diving is his first hobby. John, we learned, formerly did sky diving for a hobby, but his wife applied the screws.

Surgeon **Richard C. Margeson** joined **Kenneth Christenson** at the Pioneer Dispensary on Maui. The Medical Arts Clinic in Wahiawa announced the association of GP **Norberto Baysa** with surgeon **Manuel Abunda** and GP **Richard Tesoro**. We are indeed sorry to see **Richard Lee**, Dean of the University School of Public Health, announce his decision to retire next March 1. He is apparently caught in the same retirement benefit dilemma which affects other university and government officials. Under the present retirement plans, there are clauses which would severely reduce retirement benefits to their beneficiaries, should they die while working past their retirement dates. Dick hopes to continue on a part time basis until a successor is selected, and will then join Straub Clinic's Department of Community Medicine as head of Industrial and Occupational Medicine.

In October, yet another psychiatrist, **Waymer J. Strahm**, opened his office at the Central Medical Bldg.

Kona Hospital announced the appointment of two new physicians, general and thoracic surgeon **Gunars Medins** and plastic surgeon **John Ronald Brown**. Two senior physicians from Tripler retired from active service and will continue to work in Honolulu. **Col. William C. Hanum**, Chief of the Dept. of Psychiatry and Neurology at the Army Medical Center, will become Chief of the Prevention and Clinical Service Branch of the Mental Health Dept. of the State Dept. of Health. Navy **Cmdr. Paul E. Cook**, who headed the naval medical administrative unit will go to Queen's Medical Center as Assistant Administrator. **Walter Batchelder**, executive officer of Medical Health Services, Dept. of Health, has become health officer of the Hawaii District Office in Hilo.

Hors de Combat

Many stories emanate from the Arthur Murrays and find their way into Eddie Sherman's column. . . . It seems that when orthoped **Don Jones** operated on Arthur Murray's big toe, thoracic surgeon **Niall Scully** watched patiently for ten minutes and finally asked, "May I cut in?" Kathryn Murray was telling her friends, "During the four weeks I had the flu, I was attended by **George Ewing**. . . . You know he is a pediatrician." "That's nothing," interrupted Arthur, "When I had an ulcer, I was cured by a gynecologist. . . ." Also gleaned from Eddie Sherman's column is the following item termed House Call Deluxe. When the Horace Suttons arrived from New York for a couple of weeks of sun and relaxation at the Kahala Hilton, the McCalls and *Saturday Review* editor and family were all sniffing from colds. Sutton telephoned his friend **Ed Chesne** who meandered right over with medicine plus a fancy bottle of champagne.

We were sorry to hear that a \$50,000 fire gutted the Rodney T. Wests' home at 2715 Manoa Road. The fire started when fumes from an open can of gasoline (not continued page 148

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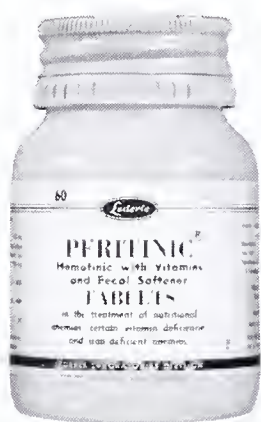
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left by the Wests) were ignited by a nearby gas heater pilot light.

Bob Krauss wrote a story in which he described how a Kahuku Hospital ambulance took over an hour to pick up a patient in Kaaawa and broke down twice enroute to the hospital. Larry Winters pointed out that the patient arrived at the hospital one hour and nine minutes after the call was received, and that the ambulance driver was forced to use his siren all the way because of the storm and traffic. This drained the electrical system and as a result the engine died on arrival at the patient's home and again after reaching the hospital. Bob Krauss said that he had no intention of making implications damaging to Kahuku Hospital and apologized for the distorted facts which came from the patient's wife. Bob had tried repeatedly to talk to the doctor and the hospital administrator but they were unavailable. There appears to have been a communications break somewhere along the line.

We saw this item in Al Ricketts' "On Waikiki": "Would you believe that at the Straub Clinic Drs. Kim and Chee have adjoining offices. . . . That is what I call a real hot item. . . ."

Nicholas Steuermann fled Romania 27 years ago to avoid Hitler's genocide plans. Nicholas was revisiting his homeland in August this year when the Russians and their allies stormed into Czechoslovakia. Rumors were rife that Romania would also be invaded, so Nicholas telephoned his wife Betty from Romania that he was leaving for Germany. But then no word. Betty spent many anxious days until Nick was able to reach Amsterdam, and was only relieved when he called from Lisbon. It may be some time before he ventures back to Europe again.

Ike Nadamoto is a sound sleeper, but may never sleep soundly again on a vacation trip. Early this year while visiting Disneyland with his wife Wini and children, a burglar entered his Anaheim motel room through a window and removed \$2,040 in cash from Ike's wallet, which the burglar generously left in the adjoining room.

In March, John Jenkin, a Hilo physician, reported the theft of 1,000 phenobarbital pills. Someone in Hilo must be on a phenobarb jag because earlier this year, 3,000 phenobarb pills were stolen from the Hilo Drug Company.

Four years ago, a ten-year-old German shepherd named Ruffy owned by the Kenneth Ings bit a woman jazz pianist on her right foot. In March this year, a circuit court jury awarded the woman \$22,761.00 for the dog bite and also gave her husband \$400 for his loss of affection while the wound was healing. Poor husband. . . . He suffered so. Speaking of dogs, it is now "the dog house" for four prize-winning Welsh Corgies belonging to the Fred M. K. Lams. In April, the Clarence M. Burgesses and the Fred M. K. Lams finally reached an agreement out of court that allows Fred to keep the dogs, but only if they are limited to "a reasonable amount of noise."

Sportsmen

Divot Diggers: Back in June and July when their games were sharp and their handicaps higher, Ed Izawa and Don Maruyama were consistent winners. In June at Mid Pac, Ed won in B flight and Don in A flight. In July, they paired up to win team best ball. Ed also copped B flight. Another Mid Pac ringer, Al Paraz, won in B flight during the month. At WCC, Mac Mitsuda finished 5 up in match vs. par and Allan Leong and partner won in team medal. Sam Yee annexed 40 points to win in stableford. Kiku Kuramoto won in B flight and Sam Yee and R. K. Chun tied with two other teams in team stableford. In August, Al Paraz again won the Mid Pac ace tournament with a net 66 and Albert Chun Hoon won in B flight in match vs. par. At the WCC, Allan Leong again won in individual stableford. Tommy Chang also won in stableford and Kiku Kuramoto tied in B flight. Next week,

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Kiku again won in B flight. At OCC, John Bell and John Bell, Jr. won the father-son tournament with 161 points. In September, we again see "ringer" Al Paraz winning in B flight best 16 of 18 tournament and then again winning in B flight stableford. (We strongly recommend that anyone winning so consistently month after month should get an automatic 10-stroke chop). At the WCC, Bill Hartwell tied in C flight and Tom Min won in B flight. Gil Freeman also tied in C flight while Toots Fujii won in B flight and Toots and Roy Tanoue tied with two other teams for team honors.

Hole-in-oners: On a memorable July 20, Douglas Murray aced the 149 yard 3rd hole at Kahuku using a 4 wood. Among the witnesses were a Mrs. Murray. Two days earlier on July 18, Hideo Oshiro had aced the 2d hole at Kaanapali using a 9 iron. But shucks, that's nothing, for anyone knows that it is harder to ace a hole with a wood than with an iron. Incidentally, there is a standing invitation from Hideo for free drinks on him at the Royal Lahaina.

Golf apparently is played on the island of Kauai as well, for Peter Kim won the Aole Makana Memorial trophy with a net 76 at the Wailua Course. He nosed out five others tied at 77, including Ken Fujii.

Going into October, Toots Fujii continued his winning streak by winning in stableford and we are happy to see Bill Ito tie in B flight with 39. Sam Yee and Tom Min won team prize with net 76. R. K. Chun and Bill Ito won in B and C flights. Tom Fujiwara and partner tied in team stableford.

At the Ala Wai, Y. Fukushima won A flight and Ed Emura placed 2d with Joe Nishimoto 12th. In B flight, H. Yokoyama was 2nd, Wally Kawaoka 3rd, Kyuro Okazaki 5th, and Tetsui Watanabe 7th.

The Thursday Club's annual presidential trophy was being hotly pursued by four close contestants, viz. Nobu Nakasone, Ed Emura, Ike Nadamoto, and H. Yokoyama. The scores for the best three out of four rounds tournament were close and Nobu Nakasone and H.

Yokoyama tied with nets 200, but H. Yokoyama won with a lower 4th round net. We learned that H. Yokoyama played with a preposterous 14 handicap (thanks to his friend, handicap chairman Frank Fukunaga) against Nobu's 8 handicap.

The Medical Arts Tournament was held on August 15 at Mid Pac. Hideo Oshiro shrewdly organized a \$10 jackpot and won his own jackpot as well as 1st prize with a net 67. Ed Izawa was 2d with net 69. Ed gave out a sigh of relief when Hideo beat him because the winner traditionally becomes next year's tournament chairman as was Don Maruyama this year. Frank Fukunaga who claims his hot putter saved the day won 3rd place with net 70. Kiku Kuramoto was MC as usual. Francis Oda had a faint blush as he stepped up to receive his prize for highest net. (But we all have our days, you know. . . .)

Yachting: Back in July, Les Vasconcellos placed 6th and last place in the 210 class. In the summer regatta, Les placed 5th and in August Les again placed 5th (i.e. 2d from last). In the 210 Invitational Regatta, "Never-Say-Die" Les was in yet another race with the winds blowing 23 mph off Waikiki. Les lost his mast when only 500 yards from the finish and had to be towed in. Poor Les. (We are still rooting for him.) In September, Ellsworth Harris won the final Hawaii Yacht Club race at Pokai Bay in his Premier Class A-1.

Fishing: The 10th Annual Hawaiian International Billfish Tournament was held in July and pathologist Dick Kelley, who in his spare time searches for billfish ulcers and last year landed the all time baby of the 10-year-old tournament, a 36½-lb. marlin, this year boated a 149-pounder on a 80-lb.-test line to put his Waikiki Rod and Gun Club in 3rd place. Dick examined the marlin stomachs and found four ulcers in the 2d largest marlin this year, a black marlin weighing 185 lbs. He reported one of the ulcers was exceptionally large and that such an ulcer in a human would have meant certain death.

continued page 152

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(REGISTERED NURSES)

Closed Circuit TV Supervisions • Provides Instantaneous Attention

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1205 ALEXANDER ST., CORNER OF BERETANIA
 NEAR CENTRAL UNION CHURCH




No one should be cold on a Caribbean cruise

To those with peripheral vascular disease, a balmy ocean breeze can become a limb-chilling wind . . . a stroll on the deck a painful, stop-and-go chore.

Priscoline can help. It dilates peripheral blood vessels, increases blood flow to extremities. Relieves numbness. Makes hands and feet less prone to chill. Makes patients more comfortable. Helps them get around.

Nothing magic about Priscoline. But people with peripheral vascular disease might think so.

See following page for prescribing information.

Priscoline[®] 
(tolazoline)
peripheral vasodilator

C I B A

Priscoline®

hydrochloride

(tolazoline hydrochloride)



Indications Spastic peripheral vascular disorders.

Precautions Tolazoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

Adverse Reactions Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

Administration and Dosage Careful individualization of dosage is required.

Oral Tablets: Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lantabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus, continuous action throughout the night is achieved without the need for arising to take additional medication.

Parenteral Subcutaneously, Intramuscularly, or Intravenously: 10 to 50 mg 4 times daily. Start with low doses, increasing with patient under close observation until optimal dosage (as determined by appearance of flushing) is established. Keeping patient warm will often increase effectiveness of drug.

Supplied Tablets, 25 mg (white, scored); bottles of 100 and 1000. **Lantabs,** 80 mg (bright yellow); bottles of 100. **Multiple-dose Vials,** 10 ml, each ml containing 25 mg tolazoline hydrochloride, 0.65% sodium citrate, 0.65% tartaric acid, and 0.5% chlorobutanol as preservative in water; cartons of 1.

Lontabs® (long-acting tablets CIBA)

Consult complete literature before prescribing.

2/3851

CIBA Pharmaceutical Company, Summit, N.J.

C I B A

Notes and News *continued from 149*

Back in June, with 126 fishermen competing for honors in the Hawaii Big Game Fishing Club spring tournament, **Tom Richert** landed a 182-lb. marlin and placed 1st in the medium tackle class and tied for 1st with a 25-lb. mahimahi in the medium tackle class. **Jim Cherry** struck out during the Billfish Tournament in Kona, but next morning hit the jackpot with a 432-lb. marlin on an 80-lb.-test outfit which was rigged for his wife Hilde. He was heard to say, "There just ain't no justice." Life is like that, Jim.

The ono (wahoo) are not so vicious as kaku (barra-cuda), but their tiny razor-like teeth can inflict serious injuries. **Louis Rockett** learned this on Labor Day off Maui when he tangled with a 47-lb. ono. As he hauled it aboard his cruiser "Susan II" it tore the flesh of his leg and almost took off his shorts. Luckily the cut was shallow and required only a few stitches.

Tennis: The President's new Council on Physical Fitness and Sports reports that: (1) One-half of America's adults, according to the AMA figures, are overweight; (2) fifty per cent of our college students fail to meet physical fitness standards; (3) the average American youngster spends ten hours watching TV for every hour spent in supervised sport or physical activity. Perhaps tennis is the answer.

From **Cal Sia's** desk came this clipping from the *Wall Street Journal* entitled "The Racket Crowd." We excerpted the following: "Everyone's for tennis. . . . Suddenly the courts are full. . . . It might be because of a new concern over health and exercise. . . . It might be because the golf courses are too crowded . . . or it might be simply that the word has spread that it is fun to play tennis. . . . Whatever the reason, everyone seems happy about the trend. . . . The players on the nation's 100,000 courts are happy because they are getting fun and exercise. . . . Makers of tennis balls are happy because they

sold 15.8 million balls last year, 50 per cent more than in 1962. Court builders are happy because they built 7,000 new courts this year . . . more than twice the number they built in 1965. Tennis still has a long way to go to catch up with golf. . . . The \$24 million that will be spent in tennis this year is less than 10 per cent of the 279 million that golfers will shell out. . . . The golfers still handily outnumber the tennis players by 10 million to four million. . . . But some golfers are defecting to the courts. . . . (Comments from defectors are as follows:) 'Golf just isn't active enough.' . . . 'Tennis is not as time-consuming as golf.' . . . We are happy to report that one of the recent defectors from golf is **Duke Choy** who with partner **Larry Wong** recently won the seven game series Sunrise Swinger Tournament held on Sunday mornings from 6:30. We must also report that we nominate **George Suzuki**, who has been playing with this group for several months, for the "Most Improved Player of the Year" award. George plays with a steel racket and has an incomparable slashing style which he uses very effectively. But we notice that **Ed Chesne** has recently abandoned his birthday gift steel racket for his old wooden one and is playing a steadier game. To each his own.

Entrepreneurs

Milton Howell of Hana, Maui, speaks with a soft Mississippi inflection. He first arrived in Hana over six years ago with his wife and family, intending to stay for only two years. He is the only physician within 75 miles and has an ambulance with four-wheel drive to reach patients who don't live on paved roads. Milton is cochairman of the "Valley of the Seven Sacred Pools" project committee and collects waterfalls like some people collect paintings. He says reverently, "There is no place on earth quite like the valley of the seven sacred pools. . . . What we must maintain is the wild beauty, not an or-



"COKE HAS THE TASTE YOU NEVER GET TIRED OF"



dered landscape beauty. . . . I am interested in conservation, but I am not a conservationist to the degree that I think plants are more important than people. . . . This is a beautiful place, to be enjoyed by everybody, and should be conserved for people. . . ."

Members Speak Up

Soft-spoken **Truett Bennett** is a man of action. He recently took his "vacation" in Vietnam as a "Volunteer Physician for Vietnam." Truett was the fourth of a hardy breed of Hawaii physicians who have thus far volunteered in this AMA sponsored program. He admitted, "I guess I volunteered through a mixture of patriotism and an opportunity for adventure. . . . I have felt quite strongly against the people who carry signs so I thought I should do whatever I can do and this seemed to be it." We need more like him . . . and we have some: **Gilbert Freeman** spent his vacation with CARE/Medico in Afghanistan.

Bob Nordyke presented a paper on the use of radioisotopes for kidney scanning on June 20 at the AMA meeting. **Ed Yamada** spoke on "Kidney Function in Relation to Anesthesia" at a bimonthly meeting of the Hawaii Association of Nurse Anesthetists at St. Francis Hospital. **Sam Buist** discussed the medical aspects of changing the laws of abortion at the Calvary Church, Kaneohe where the CBS film, "Abortions and the Law" was shown. **Joe Oren** spoke on "Asthma, the Patient and His Problems" during a workshop on chronic respiratory diseases on Kauai. **Arno Mundt**, President of the Honolulu branch of the American Obstetrical and Gynecological Society, says the society has endorsed the model law, based on the Colorado act, which permits abortions where an expectant mother's mental or physical health is endangered, in cases of rape or incest and when German measles or congenital defects could cause potential birth defects, mental retardation, or other crippling

effects. The Republicans in Hawaii endorse the Colorado law as basis for amendment of Hawaii's archaic law.

Walter Chang and **K. S. Tom** spoke to the Chinese Women's Club on cancer. **John Stephenson** would like to avoid the police state activity noticeable on some campuses in trying to enforce smoking bans, but was against the idea of a smoking room on a high school campus because it may encourage smoking by lending social prestige.

In an excellent series of articles on VD in Hawaii, **Richard Dang** estimated Hawaii's true venereal disease rate as 11,000 yearly and the teenage VD rate as two times higher than for any other group. **Ira Hirschy**, Health Dept. executive officer, on the other hand, feels that 50 per cent of the VD is in the 20-to-30 age group. Some physicians blame the increase in VD rate on the advent of the pill. But rather than the accompanying increase in sexual activity, they blame the decline in the use of the condom, which was once a very effective control on VD. **Don Char**, Professor of Public Health, says that VD is becoming a problem of the young, not just in Hawaii or even in the U.S., but in Great Britain, Sweden, Japan, and around the world. **Ira Hirschy** reports that four out of every 1,000 women taking the required prenatal blood tests in Hawaii are found to have evidence of syphilis. Ira hopes that the new State law permitting the treatment of juveniles for VD without parental consent will bring more cases to the attention of health officers and physicians around the State. Hawaii's reported cases of gonorrhea have risen from 132 in 1962 to 510 in 1967.

Bob Noyes, Chairman of the med school's Department of Anatomy, has developed a highly specific test using radioactive iodine to identify wives who have an immunity against their husbands' sperm. Studies indicate that a woman's antibody level can be reduced to normal within two to six months by curbing actual sperm contact through the use of a condom. Once the antibody level becomes normal, a fair percentage of these women are able to become pregnant. ■

Anxiety is an individual! problem



Before prescribing, please consult complete product information, a summary of which follows:

Indications: Indicated when anxiety, tension and apprehension are significant components of the clinical profile.

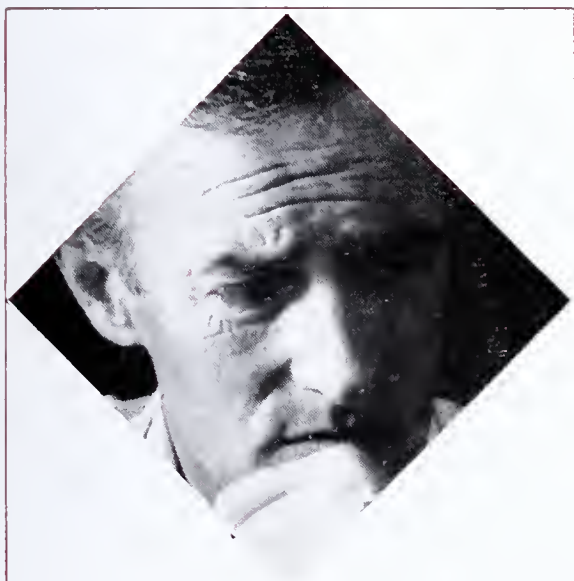
Contraindications: Patients with known hypersensitivity to the drug.

Warnings: Caution patients about possible combined effects with alcohol and other CNS depressants. As with all CNS-acting drugs, caution patients against hazardous occupations requiring complete mental alertness (e.g., operating machinery, driving). Though physical and psychological dependence have rarely been reported on recommended doses, use caution in administering to addiction-prone individuals or those who might increase dosage; withdrawal symptoms (including convulsions), following discontinuation of the drug and similar to those seen with barbiturates, have been reported. Use of any drug in pregnancy, lactation, or in women of child-bearing age requires that its potential benefits be weighed against its possible hazards.

Precautions: In the elderly and debilitated, and in

children over six, limit to smallest effective dosage (initially 10 mg or less per day) to preclude ataxia or oversedation, increasing gradually as needed and tolerated. Not recommended in children under six. Though generally not recommended, if combination therapy with other psychotropics seems indicated, carefully consider individual pharmacologic effects, particularly in use of potentiating drugs such as MAO inhibitors and phenothiazines. Observe usual precautions in presence of impaired renal or hepatic function. Paradoxical reactions (e.g., excitement, stimulation and acute rage) have been reported in psychiatric patients and hyperactive aggressive children. Employ usual precautions in treatment of anxiety states with evidence of impending depression; suicidal tendencies may be present and protective measures necessary. Variable effects on blood coagulation have been reported very rarely in patients receiving the drug and oral anticoagulants; causal relationship has not been established clinically.

Adverse Reactions: Drowsiness, ataxia and confusion may occur, especially in the elderly and debilitated. These are reversible in most instances by proper dosage adjustment, but are also occasionally ob-



**Because anxiety varies widely
from patient to patient . . .**

antianxiety Librium (chlordiazepoxide HCl) has been made available in several dosage strengths. Thus, Librium in doses of 20 or 25 mg t.i.d. is often effective in helping to control the more severe anxiety that may develop during periods of acute stress.

In lower doses of 5 or 10 mg three or four times daily, Librium helps alleviate symptoms of the more commonly seen mild to moderate anxiety. Also, mental acuity is generally preserved on proper maintenance dosage.

**for relief of
more severe anxiety**

Librium®
(chlordiazepoxide HCl)
25-mg capsules

when tablets are preferred

Libritabs™
(chlordiazepoxide)
25-mg tablets

served at the lower dosage ranges. In a few instances syncope has been reported. Also encountered are isolated instances of skin eruptions, edema, minor menstrual irregularities, nausea and constipation, extrapyramidal symptoms, increased and decreased libido—all infrequent and generally controlled with dosage reduction; changes in EEG patterns (low-voltage fast activity) may appear during and after treatment; blood dyscrasias (including agranulocytosis), jaundice and hepatic dysfunction have been reported occasionally, making periodic blood counts and liver function tests advisable during protracted therapy.

Usual Daily Dosage: Individualize for maximum beneficial effects. *Oral*—Adults: Mild and moderate anxiety and tension, 5 or 10 mg t.i.d. or q.i.d.; severe states, 20 or 25 mg t.i.d. or q.i.d. Geriatric patients: 5 mg b.i.d. to q.i.d. (See **Precautions.**)

Supplied: Librium® (chlordiazepoxide HCl) Capsules, 5 mg, 10 mg and 25 mg—bottles of 50. Libritabs™ (chlordiazepoxide) Tablets, 5 mg, 10 mg and 25 mg—bottles of 100. With respect to clinical activity, capsules and tablets are indistinguishable.



Roche®
LABORATORIES

Division of Hoffmann-La Roche Inc
Nutley, New Jersey 07110



Knee-deep

in osteoarthritic pain

If aspirin doesn't help, move in with Tandearil.

The trial period is brief: 1 week. Try one tablet q.i.d. at first. Tandearil usually starts working within 3 to 4 days. When response occurs, as little as 1 or 2 tablets daily may hold back pain and stiffness, and increase joint motion.

On the next page is a summary of adverse reactions, contraindications, warning and precautions.

Tandearil.
It can help get his mind off his knee.

Please review full Prescribing Information carefully before prescribing.

For osteoarthritic knees, spines, shoulders, hips, etc.:

Tandearil[®]
oxyphenbutazone



Tandearil[®]

oxyphenbutazone

Contraindications: Edema; danger of cardiac decompensation; history or symptoms of peptic ulcer; renal, hepatic or cardiac damage; history of drug allergy; history of blood dyscrasia. The drug should not be given when the patient is senile or when other potent drugs are given concurrently.

Warning: This drug is an analog of phenylbutazone; sensitive patients may be cross-reactive. If coumarin-type anticoagulants are given simultaneously, watch for excessive increase in prothrombin time. Instances of severe bleeding have occurred. Persistent or severe dyspepsia may indicate peptic ulcer; perform upper gastrointestinal x-ray diagnostic tests if drug is continued. Pyrazole compounds may potentiate the pharmacologic action of sulfonyleurea, sulfonamide-type agents and insulin. Carefully observe patients receiving such therapy. Use with caution in the first trimester of pregnancy, and in patients with thyroid disease.

Precautions: Before prescribing, carefully select patients, avoiding those responsive to routine measures as well as contraindicated patients. Obtain a detailed history and a complete physical and laboratory examination, including a blood count. The patients should not exceed recommended dosage, should be closely supervised and should be warned to discontinue the drug and report immediately if fever, sore throat, or mouth lesions (symptoms of blood dyscrasia), sudden weight gain (water retention), skin reactions, black or tarry stools or other evidence of intestinal hemorrhage occur. Make complete blood counts at weekly intervals during early therapy and at 2-week intervals thereafter. Discon-

tinue the drug immediately and institute countermeasures if the white count changes significantly, granulocytes decrease, or immature forms appear. Use greater care in the elderly and in hypertensives.

Adverse Reactions: The more common are nausea and edema. Swelling of the ankles or face may be minimized by withholding dietary salt, reduction in dosage or use of diuretics. In elderly patients and in those with hypertension, the drug should be discontinued with the appearance of edema. The drug has been associated with peptic ulcer and may reactivate a latent peptic ulcer. The patient should be instructed to take doses immediately after meals or with milk to minimize gastric upset. Drug rash occasionally occurs. If it does, promptly discontinue the drug. Agranulocytosis, exfoliative dermatitis, Stevens-Johnson syndrome, Lyell's syndrome (toxic necrotizing epidermolysis), or a generalized allergic reaction similar to a serum sickness syndrome may occur and require permanent withdrawal of medication. Agranulocytosis can occur suddenly in spite of regular, repeated normal white counts. Stomatitis, salivary gland enlargement, vomiting, vertigo and languor may occur. Leukemia and leukemoid reactions have been reported. While not definitely attributable to the drug, a causal relationship cannot be excluded. Thrombocytopenic purpura and aplastic anemia may occur. Confusional states, agitation, headache, blurred vision, optic neuritis and transient hearing loss have been reported, as have hyperglycemia, hepatitis, jaundice, hypersensitivity angitis, pericarditis and several cases of anuria and hematuria. With long-term use, reversible thyroid hyperplasia may occur infrequently. Moderate lowering of the red cell count due to hemodilution may occur.


Dosage in Osteoarthritis: Initial: 3 to 6 tablets daily in divided doses. Usually unnecessary to exceed 4 tablets daily. A trial period of one week is considered adequate to determine the therapeutic effect of the drug. Maintenance: Effective level often achieved with 1 or 2 tablets daily, should not exceed 4 tablets daily.

In selecting appropriate dosage in any specific case, consideration should be given to the patient's weight, general health, age and any other factors influencing drug response.

Availability: Tan, round, sugar-coated tablets of 100 mg. in bottles of 100 and 1000.

(B)R-46-800-A

For complete details, please see full Prescribing Information.

 Geigy Pharmaceuticals
Division of
Geigy Chemical Corporation
Ardsley, New York 10502

With improved ventilatory efficiency...
he can be part of the family again



An "Isuprel®-break" q.i.d. every day with the Mistometer® can reduce the work of breathing by helping to free the airway. Isuprel relaxes bronchospasm, aids elimination of trapped mucus, helps improve respiratory function.

Isuprel dilates bronchi speedily and facilitates expulsion of tenacious bronchial plugs. Clean airways facilitate ventilation of the alveoli.*

The Isuprel Mistometer is a complete nebulizing unit, compact, always ready for use without shak-

ing. The translucent vial contains 15 ml. of Isuprel hydrochloride 1:400 or 0.25 per cent w/w (=2.8 mg. per ml.) in inert propellants (dichlorodifluoromethane and dichlorotetrafluoroethane) with aromatic flavor, alcohol 33 per cent and, as preservative, ascorbic acid 0.1 per cent. The Mistometer provides economy—about a penny each for about 300 single oral inhalations. Prescribe a deep inhalation (approximately 125 mcg.) three or four times daily.

*Lyons, H. A.: J.A.M.A. 194:1234, Dec. 13, 1965.

in chronic bronchitis
and emphysema complicated
by bronchospasm

ISUPREL[®] HCl
brand of
isoproterenol HCl
MISTOMETER[®] q.i.d.

Contraindication: Use of isoproterenol in patients with preexisting cardiac arrhythmias associated with tachycardia is generally considered contraindicated because the cardiac stimulant effect of the drug may aggravate such disorders.

Warnings: Excessive use of an adrenergic aerosol should be discouraged as it may lose its effectiveness.

Occasional patients have been reported to develop severe paradoxical airway resistance with repeated, excessive use of isoproterenol inhalation preparations. The cause of this refractory state is unknown. It is advisable that in such instances the use of this preparation be discontinued immediately and alternative therapy instituted, since in the reported cases the patients did not respond to other forms of therapy until the drug was withdrawn. Deaths have been reported following excessive use of isoproterenol inhalation preparations and the exact cause is unknown. Cardiac arrest was noted in several instances.

Precautions: Epinephrine should not be administered with Isuprel, brand of isoprote-

renol, as both drugs are direct cardiac stimulants and their combined effects may induce serious arrhythmia. If desired they may, however, be alternated, provided an interval of at least four hours has elapsed. Isoproterenol should be used with caution in patients with cardiovascular disorders including coronary insufficiency, diabetes, or hyperthyroidism, and in persons sensitive to sympathomimetic amines.

During the course of 20 years of use of Isuprel there has been no clinical evidence of teratogenic effects. However, use of any drug in pregnancy, lactation, or in women of child-bearing age requires that the potential benefit of the drug be weighed against its possible hazards to the mother or child.

Adverse Reactions: The mist from the Isuprel Mistometer contains alcohol but is generally very well tolerated. An occasional patient may experience some transient throat irritation which has been attributed to the alcohol content.

Tachycardia, palpitation, nervousness, nausea, and vomiting may occur from overdosage, especially when the sublingual tablets are used. Rarely, do headache, flushing of

the skin, tremor, dizziness, weakness, sweating, precordial distress, or anginal-type pain occur. The inhalation route is usually accompanied by a minimum of side effects. These untoward reactions disappear quickly and do not, as a rule, inconvenience the patient to the extent that the drug must be discontinued. No cumulative effects have been reported.

Dosage and Administration: Bronchial Asthma: Mistometer—Holding the Mistometer in an inverted position, a single deep inhalation generally will afford control of an acute attack; a full minute should be allowed to elapse in order to determine this effect before a second inhalation is considered. Try to hold breath for a few seconds before exhaling. Occasionally a second inhalation may be necessary.

Emphysema, Chronic Bronchitis: Oral inhalation doses are the same as for asthma, repeated three or four times daily.

Winthrop Winthrop Laboratories
New York, N.Y. 10016

concurrent with the protocol set up. It was pointed out that this matter was brought before the HCMS Board of Governors and they felt that it was not necessary for the Board to endorse this project because it was really a matter between the hospital records committee, the involved patient and the private physician.

ACTION:

It was voted to endorse the proposal for a biliary atresia study.

Straub Medical Research Institute: A letter to Mr. Miyamoto from the Straub Medical Research Institute was received requesting approval of a follow-up study of a small group of CEP patients over the next nine months.

ACTION:

It was voted that the HMA endorse this program provided it is done within the next nine months.

Maui County Resolution: The following Resolution was presented to the Council by the Maui County Medical Society re the Medical Practice Act.

Medical Practice Act

WHEREAS, Every year bills are introduced in the Hawaii State Legislature which would change the Medical Practice Act; and

WHEREAS, The bills that are introduced in the Legislature are not introduced under sponsorship of the Hawaii Medical Association or by the Maui County Medical Society; and

WHEREAS, It is the intent and purpose of the Hawaii Medical Association and the Maui County Medical Society to safeguard the health of the people of the State of Hawaii; and

WHEREAS, Chapter 70-12 of the Revised Laws of Hawaii states "In public institutions osteopathic physicians and osteopathic physicians and surgeons licensed hereunder shall have the same privileges and the same rights to practice their profession in the treatment of cases and the same right to hold office as are accorded to physicians and surgeons of other schools"; and

WHEREAS, The requirements for licensure of Medical and Osteopathic physicians in the State of Hawaii are not equal with regard to (1) residence requirement, and (2) examination; and

WHEREAS, Under these circumstances, public institutions providing medical services would, and do, have difficulty in determination of granting of privileges and thereby certifying to the public that ability to provide medical care is equal in the two groups licensed in two different manners; and

WHEREAS, Doctors of Medicine object to this inequity in the law; now be it

Resolved that the Maui County Medical Society does not approve of the practice of medicine in the State by any physician, medical or osteopathic, not examined by the Board of Medical Examiners of the State of Hawaii, and found to be of good moral character and professionally competent, except as may be provided by law for government service, for internship, for local emergencies; and be it further

Resolved that the Legislative Committee and the Commission on Legislation of the Hawaii Medical Association exert every effort to have passed by the Hawaii State Legislature during the 1969 Session legislation which would amend the Medical Practice Act by adding a provision that all physicians and surgeons applying for licensure to practice medicine or surgery under the provisions of Chapter 64 or Chapter 70 of the Revised Laws of Hawaii be required to pass the same examination.

Adopted: June 18, 1968
Maui County Medical Society

The Council was advised that this Resolution was discussed at the Medical Practice Act Committee and that the Committee Chairman has written to various states to check state laws relative to osteopaths.

ACTION:

It was voted that the Council refer this resolution from the Maui County Medical Society to the Medical Practice Act Committee for action.

It was voted that the HMA adopt this Resolution.

REPORT OF THE SECRETARY

The Secretary's Report was presented and discussed and the following recommendations were acted on:

ACTION:

It was voted that all roster changes reported by the counties for the months of March, April, May, June, July, August, and September, 1968, be accepted and approved.

It was voted that in view of the bylaws study
continued page 162

ACHROMYCIN® V TETRACYCLINE

Contraindications: Hypersensitivity to tetracycline.

Warning: In renal impairment, since liver toxicity is possible, lower doses are indicated; during prolonged therapy consider serum level determinations. Photodynamic reaction to sunlight may occur in hypersensitive persons. Photosensitive individuals should avoid exposure; discontinue treatment if skin discomfort occurs.

Precautions: Nonsusceptible organisms may overgrow; treat superinfection appropriately. Tetracycline may form a stable calcium complex in bone-forming tissue and may cause dental staining during tooth development (last half of pregnancy, neonatal period, infancy, early childhood).

Side Effects: *Gastrointestinal*—anorexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. *Skin*—maculopapular and erythematous rashes; exfoliative dermatitis; photosensitivity; onycholysis, nail discoloration. *Kidney*—dose-related rise in BUN. *Hypersensitivity reactions*—urticaria, angioneurotic edema, anaphylaxis. *Intracranial*—bulging fontanels in young infants. *Teeth*—yellow-brown staining; enamel hypoplasia. *Blood*—anemia, thrombocytopenic purpura, neutropenia, eosinophilia. *Liver*—cholestasis at high dosage.

Upon adverse reaction, stop medication and treat appropriately.



LEDERLE LABORATORIES
A Division of
American Cyanamid Company
Pearl River, New York 10965

359-8

suspected tetracycline-sensitive infection?

**While waiting for the results of the sensitivity test,
start the therapy likely to succeed...**

Although of course it can't replace routine sensitivity testing, your prescription for ACHROMYCIN® V, in a way, provides the ultimate test of therapy under rigorous *in vivo* conditions.

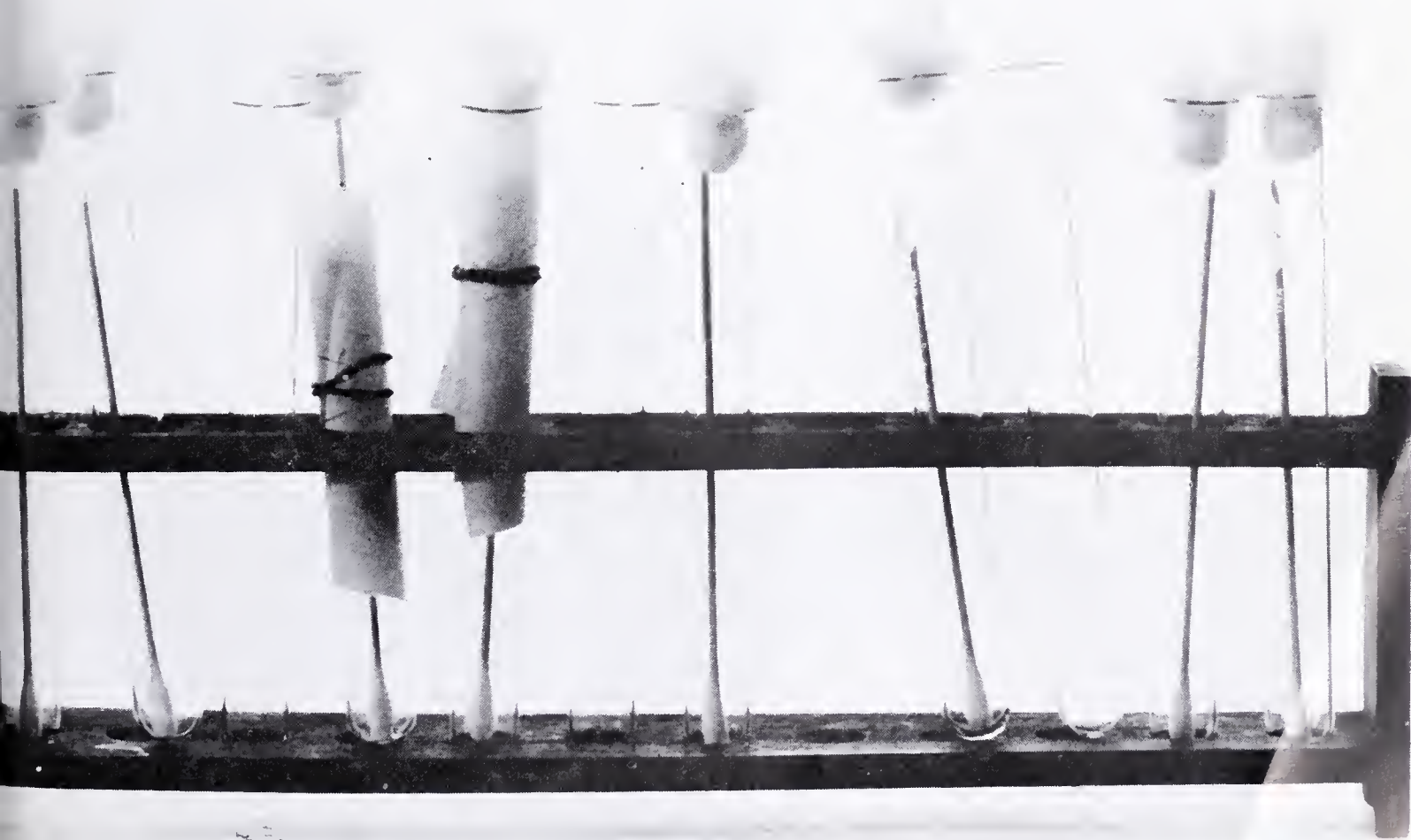
Because ACHROMYCIN® V is effective in treating so many common infections—caused by strains of tetracycline-sensitive organisms—doesn't *stat* dosage of this time-tested antibiotic make good sense?

—Prescribing Information

ACHROMYCIN® V
TETRACYCLINE



*The price differential
is inconsequential.*



being made, no action be taken at this time relative to the status of the four inactive Honolulu County members who hold unlimited licenses.

It was voted to approve the Secretary's report as circulated.

REPORT OF THE TREASURER

The Treasurer's Report was presented and discussed and the following recommendations were acted on:

ACTION:

It was voted that when only one member of a family of two or more is a wage earner, the HMA pay the full amount charged by the Foundation for family coverage.

It was voted that the \$1,500 for the Oahu Country Club transferable membership continue to be held in the suspense account.

It was voted that outstanding accounts for the JOURNAL and Roster which are more than nine months old be written off.

It was voted that Mr. Rice advise Unigraphic through their attorney that no further efforts will be made to collect the outstanding accounts for layout and that as far as the HMA is concerned this matter is closed.

At the last Council meeting the Treasurer recommended that if the House of Delegates changed the Bylaws to permit inactive membership for physicians not in private practice, even though they may be licensed, that the dues for this class of membership be increased from \$2.00 to \$47.00. The Council at that time voted to postpone this recommendation until the next Council meeting pending clarification of membership status of these doctors by the House of Delegates. It was noted in

the Secretary's report that there are members who are carried as inactive members.

ACTION:

It was voted that the dues for inactive members be set at \$47.00 for 1969.

The anticipated income from *What Goes On* probably may be reduced since Lederle is discontinuing financial support of this project after 1968. The California Medical Association has received financial support from RMP to continue the project for that State only. Information has been requested from them on the cost for continuing Hawaii on the present basis. This information has not been received. An information inquiry has been entered with the Hawaii RMP for funds but no formal reply has been received.

ACTION:

It was voted to have the HMA submit an application through the Hawaii RMP for funds to continue publication in *What Goes On*, and if this is turned down, the HMA request funds through the California RMP.

REPORT OF COMMISSIONS AND COMMITTEES

Bureau of Planning and Research: The report was circulated and noted.

ACTION:

It was voted to approve the report.

Finance Committee: The report was circulated and noted.

ACTION:

It was voted to accept this report.

Commission on Education and Research: This report continued page 164

Professional people are steering to Hawaii Leasing for attractive auto leasing arrangements. A new automobile, with radio, power steering and automatic transmission can be leased for as little as \$2.60 per day. No costly repair bills... the manufacturer's warranty is passed on to you. Earlier new car replacement — and many tax saving advantages. Call us. We have the figures to prove our point.

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LET US PUT YOU BEHIND THE WHEEL



things go
better
with
Coke



BOTTLED UNDER AUTHORITY OF THE COCA-COLA COMPANY BY
COCA-COLA BOTTLING COMPANY OF HONOLULU, INC.

Dilantin[®] (diphenylhydantoin)

PARKE-DAVIS

For untold thousands of
epileptic patients...
Dilantin has been, and
continues to be, the
bedrock of therapy.

DILANTIN is useful in the treatment of grand mal epilepsy and certain other convulsive states. Its use will prevent or greatly reduce the incidence and severity of convulsive seizures in a substantial percentage of epileptic patients, without the hypnotic and narcotizing effects of many anti-convulsant drugs.

PRECAUTIONS: Periodic examination of the blood is advisable. Nystagmus in combination with diplopia and ataxia indicates dosage should be reduced. The possibility of toxic effects during pregnancy has not been explored. **ADVERSE**

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was circulated and discussed. The following recommendations were made: (1) That the reports of the committees in this commission be accepted and that they continue along the lines they are establishing. (2) That the HMA study the intent of PL 89-239 and determine if the RMP operation in Hawaii is in line with the intent of Congress. (3) That the HMA concur with the idea of a cooperative organization for continuing education under the leadership of HMA through RMP funding and other resources.

ACTION:

It was voted to approve all recommendations of this Commission. The Chairman of this Commission was asked to have Medical Education Commission study PL 89-239.

Commission on Internal Affairs: The report was circulated and discussed. The following recommendations were made and acted upon: (1) Inasmuch as 155 HMA members have indicated an interest in attending the Hilo meeting and in addition rooms will be needed for mainland doctors, guest speakers, exhibitors, and staff members, the Arrangements Committee should be instructed to see that sufficient accommodations are obtained.

ACTION:

It was voted to approve this report.

The Council was advised that the Arrangements Committee met October 23, 12:30 P.M. and that the Naniloa Hotel has promised 70 rooms for guest speakers, Delegates, and staff members. It was further noted that 30 additional rooms were reserved at other hotels.

Commission on Legislation: The report was circulated and discussed. The following recommendations were made and acted upon: (1) That the Council give the Legislative Committee the requested guidance in relation

to differential fees. (2) That the Council set priorities for items A, B, C, and D noted above. (3) That the Council adopt an official position for HMA relative to a cut in Title XIX matching funds.

ACTION:

On Recommendation No. 1 it was voted that negotiations with carriers be re-evaluated in the context of using usual, customary, and reasonable fees rather than the Relative Value Study at a conversion factor.

On recommendation No. 2 it was voted to leave priorities for study mandated by the House of Delegates up to the Legislative Committee.

On recommendation No. 3 it was voted that the HMA oppose any action relative to a cut in Title XIX matching funds.

Commission on Medical Services: The report was circulated and discussed. The following recommendations were made and acted on: (1) That the Workmen's Compensation Committee be permitted to postpone working for legislative changes approved by the House of Delegates until such time as the committee feels it is appropriate to ask for these changes, and the Legislative Committee be advised of this action. (2) That the Workmen's Compensation Committee be asked to pursue the matter of a public hearing and to develop the necessary petition for circulation to the Council prior to being sent to the Department of Labor. (3) That the Medical Care Plans Committee study the present philosophy of a fee schedule based on the RVS versus third-party reimbursement to physicians on a usual and customary basis.

ACTION:

It was voted to approve all recommendations.

Commission on Public Health: The report was circulated and discussed. The following recommendations were made and acted on: (1) That the HMA Council accept

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the recommendation of the Automotive Safety Committee and endorse the Department of Health's Injury Control Program. (2) That the HMA accept the recommendations of the Cancer Committee and endorse the three proposed programs of the American Cancer Society—Hawaii Division. (3) That if the official notification of RMP is that the Hawaii Tumor Registry grant application is not approved, that the Cancer Committee instruct the Cancer Commission to immediately start working on a revision that will assure the grant application's acceptance. (4) That the Diabetes Committee be given approval in principle to draw up a program of diabetes screening for the Trust Territory, but before a firm commitment is made, the protocol be submitted for final approval.

ACTION:

It was voted to accept all recommendations of the Commission.

Commission on Interprofessional and Public Relations. The report was circulated and discussed. The following recommendations were made and acted on:

(1) That \$500 be allocated to the Medicine and Religion Committee to send one of its members to the March 29 meeting in Utah. (2) That physicians who write articles for the newspapers be permitted to use their names as bylines for the articles that are used.

The News Media Committee is desirous of obtaining Council permission for the doctors who write articles for the newspapers to be able to use their names as bylines for the articles they write. The Committee felt it would give more physicians an incentive to write if this were approved. The Council did not feel it was necessary for physicians to use their names as bylines. There was considerable discussion re this matter.

(3) That the \$150 the House of Delegates allocated for a luncheon for Auxiliary members who assist with deliv-

eries of the Message of the Month, be diverted to the Auxiliary for the purchase of a health film.

ACTION:

It was voted that recommendation No. 1 not be accepted.

It was voted that recommendation No. 2 be not approved and that the News Media Committee continue to explore the possibility of getting articles in the paper without use of bylines.

It was voted to approve recommendation No. 3.

UNFINISHED BUSINESS

Invitation to AMA: A letter was received from Dr. Milford O. Rouse, Immediate Past President of the AMA requesting that the HMA extend an official invitation to the AMA to hold a Clinical Session in Hawaii. He also suggested that the official invitation be accompanied by an invitation from the Chamber of Commerce and the Governor.

ACTION:

It was voted to extend an invitation to the AMA to hold its Clinical Session in Honolulu.

NEW BUSINESS

Report from Mr. V. Thomas Rice on Medical Ethics and Legal Conference Meetings: Mr. Rice reported that he attended this Conference on August 4, 5, and 6, in Chicago and gave a few highlights of the Conference as follows: (1) There was a talk by the Ohio State Medical Association's legal counsel who lectured on a malpractice insurance program which was put together very loosely but is working. (2) The attorney from the California Medical Association reviewed the two-year legis-

continued page 166



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lative program in the malpractice field. (3) There was discussion of liability for paramedical personnel and the answer is simple—that the physicians are liable for them. (4) There was a lecture on state regulation of clinical laboratories. (5) There was a group session where problems were aired. (6) There was a lecture on the legal problems of hospital emergency rooms. (7) There was a lecture on new tax developments for the medical profession. (8) There was a talk on current Medicare problems. He noted that there were 150 bills presented relating to Medicare. (9) There was a report by the counsel for the Kansas Medical Society relative to the revocation of a license of an incompetent physician. Mr. Rice pointed out that the problems we have in Hawaii are not unique—every state association or society has similar problems. He noted that Hawaii is not so aggressive as some of the other states. (10) The conference on ethics was very informative and enjoyable. (11) There was a lecture on discipline. The main emphasis was that the physicians should get their house in order and initiate discipline whenever necessary.

Mr. Rice stated that the primary recommendation of the Conference on Medical Ethics was to "learn to distinguish between ethics and etiquette." He further reported that out of this Conference he learned that we, in Hawaii, are faced with the same problems other states are faced with and that they do not have any more ready solutions than we do.

Report by Dr. Moore on forthcoming AMA Clinical Session: Dr. Moore stated that he did not have a formal report to make since he has not yet received his AMA handbook. There will probably be numerous resolutions introduced. He further noted that there will probably be considerable discussion re RMP programs and on the change of the executive leadership of the AMA.

Election of Community Research Bureau Officers: Dr.

Chinn reported that a Board meeting was held just before the Council meeting. Those present were Drs. Miyamoto, Chinn, Mills, and Uehara to prepare a slate of officers.

ACTION:

The following were elected to hold office in the Community Research Bureau for 1968-69: President, B. A. Richardson, M.D.; Vice President, O. D. Pinkerton, M.D.; Secretary, Sakae Uehara, M.D.; and Treasurer, Herbert Y. H. Chinn, M.D.

Miscellaneous Business: At this time, Dr. Richard Moore asked that the Council consider the resolution he circulated regarding the Regional Medical Program in Hawaii. There was considerable discussion regarding this resolution and the Council felt that there should be another meeting to discuss the matter before acting on the adoption of the resolution.

ACTION:

It was voted that a meeting be scheduled and that Dr. Masato Hasegawa, Director of the Regional Medical Program in Hawaii, and his Steering Committee be invited to a confrontation regarding the resolution submitted by Dr. Moore which would express the HMA's disapproval and request a complete change in the organization of the RMP.

It was recommended that the members of HMA be notified by mail that the Council will be meeting with this group and if any physicians have any suggestions disapproving or approving the matter that they be instructed to inform the HMA offices.

The meeting was adjourned at 11:55 P.M.

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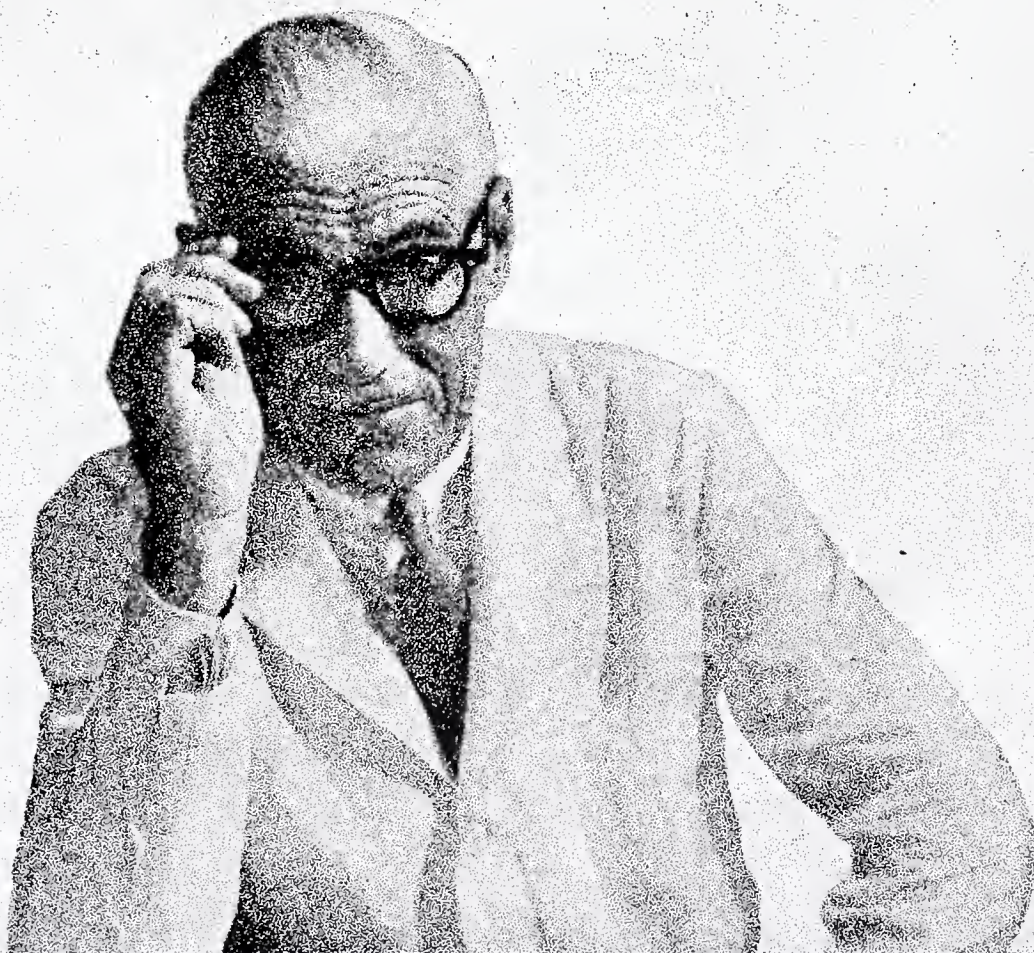
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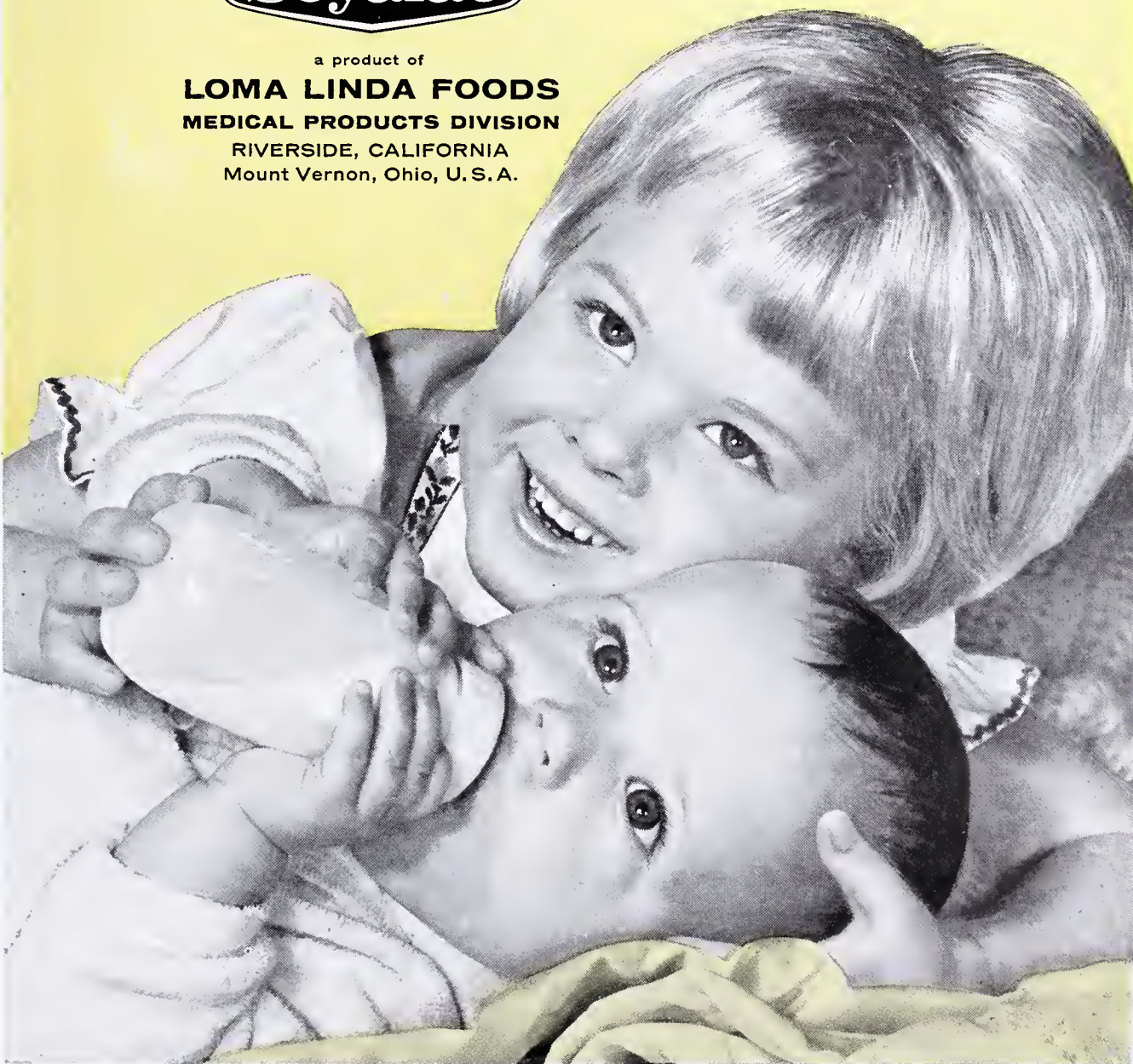
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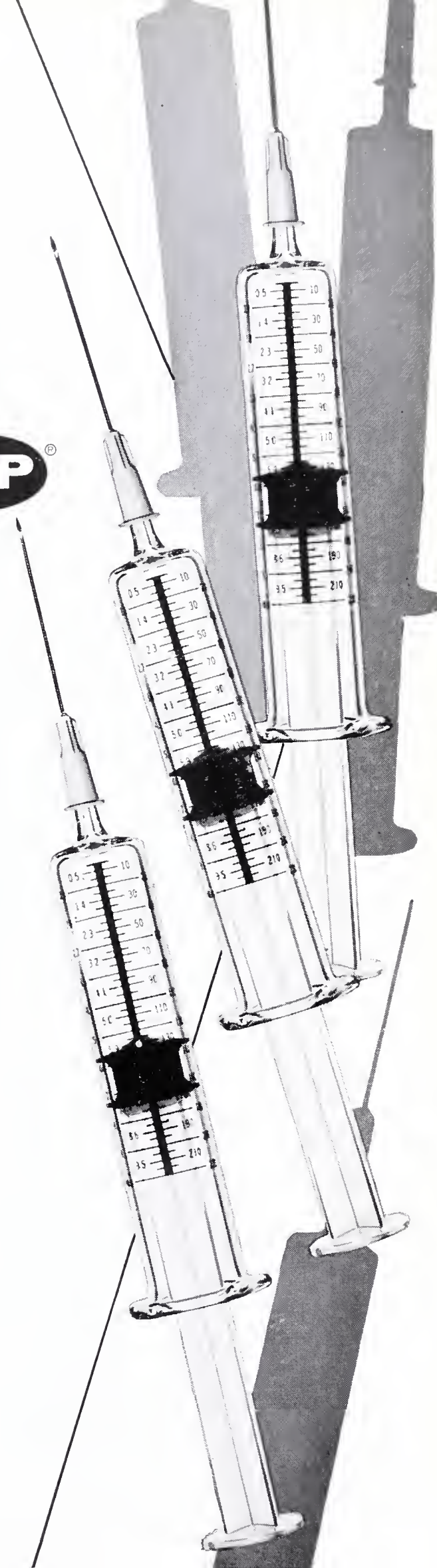
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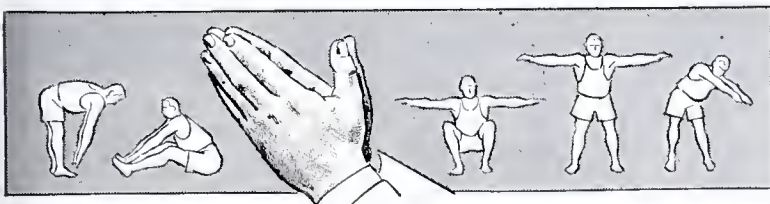


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Careful management and control of urinary acidification is stressed. Urine pH should be maintained and dietary and/or supplemental acidification adjusted as required. This program controlled many previously intractable urinary infections.

1. Hosp. Med. 4:73 (May) 1968.
2. Scientific Exhibit — "The Control of Recurrent Bacteriuria," U.S.P.H.S. Cooperative Study, Shown at A.M.A. Clinical Convention, Houston, Texas, November 26-29, 1967.
3. Am. J. Dis. Child. 105:560, 1963.

Indications: Mandelamine (methenamine mandelate) is indicated for the suppression or elimination of bacteriuria associated with pyelonephritis, cystitis and other urinary tract infections; also for infected residual urine sometimes accompanying neurologic diseases. When used as recommended, Mandelamine (methenamine mandelate) is particularly suitable for long-term therapy because of its safety and because resistance to the nonspecific bactericidal action of formaldehyde does not develop. Pathogens resistant to other antibacterial agents may respond to Mandelamine (methenamine mandelate) because of the nonspecific bactericidal effect of formaldehyde formed in an acid urine.

Contraindication: Contraindicated in renal insufficiency.

Dosage and Management: Adults — 1 Gm. *q.i.d.* Since an acid urine is essential for antibacterial activity with maximum efficacy occurring at pH 5.5 or below, restriction of alkalinizing foods and medication is desirable. If testing of urine pH reveals the need, supplemental acidification should be given. (See Precautions.)

Long-term therapy in a continuing study of adult males²

A continuing study in seven U.S. Public Health Service hospitals demonstrates the efficacy of Mandelamine in controlling recurrent bacteriuria in adult males. Initial broad-spectrum antibiotic therapy eradicated bacteriuria in 88 percent of 122 patients. Then each of these patients was placed randomly in one of four treatment groups. After 13 months, the rate of recurrence of bacteriuria in these males was found to be lower with all antibacterials, as compared with placebo, and the rate was lowest with Mandelamine.

Long-term therapy in children³

A series of twenty young girls (14 months to 12½ years old) presented a history of 160 documented urinary tract infections, 46 requiring hospitalization, while receiving intermittent antibiotic or sulfonamide therapy. The rate of recurrence was strikingly reduced following the institution of a regimen of prophylactic therapy utilizing Mandelamine (methenamine mandelate) and a urinary acidifying agent. During the treatment period (an average of 2.25 years) only five patients failed to respond.

A logical choice

There has been increasing interest in the use of long-term suppressive therapy, although the benefits are not yet fully established. However, when the decision is made to utilize long-term suppressive therapy, Mandelamine is a logical choice. Particularly when utilized immediately after antibiotic therapy, Mandelamine, in conjunction with a urinary acidifier, if necessary, is a highly useful agent in preventing recurrences of bacteriuria. Through its local action in the urine, Mandelamine exerts its antibacterial effect against a wide range of gram-negative and gram-positive pathogens. Major toxicity is almost never a cause for discontinuing therapy, although mild reactions — skin rash, dysuria, gastrointestinal upset — may occur. Cost to the patient is relatively low — an important consideration when initiating long-term therapy.

	Dosage Form	Dosage
1 Gm.	Mandelamine Tablets (methenamine mandelate)	<i>Adults:</i> 1 tablet <i>q.i.d.</i>
	Mandelamine Suspension Forte (methenamine mandelate) 500 mg./tsp.	<i>Children 6-12:</i> 1 teaspoonful or 1 tablet <i>q.i.d.</i>
½ Gm.	Mandelamine ½ Gm. Tablets (methenamine mandelate)	<i>Adults:</i> 2 teaspoonfuls or 2 tablets <i>q.i.d.</i>
	Mandelamine Suspension (methenamine mandelate) 250 mg./tsp.	<i>Children 5 or under:</i> 1 teaspoonful or 1 tablet per 30 lb. body weight <i>q.i.d.</i>
¼ Gm.	Mandelamine ¼ Gm. Tablets (methenamine mandelate)	

Precautions: Dysuria may occur (usually at higher than recommended dosage). This can be controlled by reducing the dosage and/or acidification. When urine acidification is contraindicated or unattainable (as with some urea-splitting bacteria), the drug is not recommended.

Adverse Reactions: An occasional patient may experience gastrointestinal disturbance or a generalized skin rash.

Full information is available on request.

WARNER-CHILCOTT
Morris Plains, New Jersey



MANDELAMINE[®]

(methenamine mandelate)

Logical long-term urinary antibacterial



Photo professionally posed.

No injection after all!

This penicillin produces high, fast levels—orally.

Pen•Vee® K is usually so rapidly and completely absorbed that therapeutic penicillin levels are attained within 15 to 30 minutes. Thus it can often obviate the need for penicillin injections. The higher serum levels produced generally last longer than with those of oral penicillin G.

Indications: Infections susceptible to oral penicillin G; prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization): Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

ORAL **PEN•VEE® K**
(potassium phenoxymethyl penicillin)



Syntex announces

New hormone ratio in low-dosage oral contraception

Norinyl[®]

1+80

(norethindrone 1 mg with mestranol 0.08 mg)

21&28

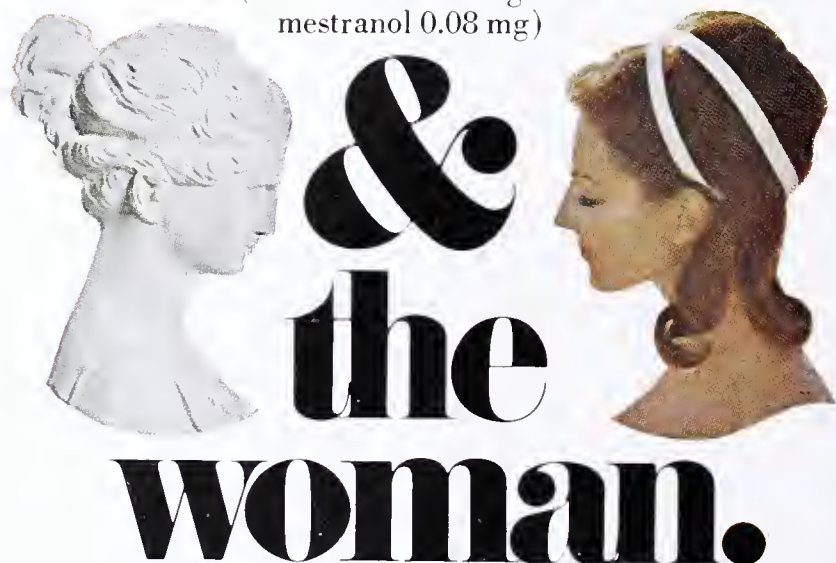
day regimens



Please see last page of advertisement for prescribing information.

Norinyl[®] 1+80

(norethindrone 1 mg with
mestranol 0.08 mg)



Oral contraceptives are different because women are different.

Just being secure in the knowledge that her oral contraceptive is effective is not enough. She also wants to be secure in the knowledge that her oral contraceptive is right for her.

Now you have a new choice in prescribing a low-dosage oral contraceptive.

Norinyl 1+80 is a new combination, consisting of 1 milligram norethindrone and a slightly increased amount of mestranol (80 micrograms instead of the usual 50). This important adjustment may be particularly suitable for her if she requires a slightly higher ratio of estrogen.

And it's the woman who must accept her oral contraceptive.

Please see last page of advertisement for prescribing information.



The woman & her regimen

No matter how effective her oral contraceptive is... if she forgets, she loses the protection she's striving for.

Norinyl® 1+80 gives her the easiest regimen choice possible: either 21-day (3 weeks on, 1 week off) or 28-day continuous therapy (21 active tablets and 7 placebos). Both are simple and regular. Cycle days are replaced by weekdays — the way she lives her life.

& the new Memorette®

Norinyl 1+80 comes to her in the new Memorette tablet dispenser. Feminine and attractive. Designed for the modern woman who has more on her mind than medication. No charts or calendars... just the beautiful Memorette for her convenience.



Norinyl®

1+80

(norethindrone 1 mg with
mestranol 0.08 mg)

21 & 28 day regimens

CONTRAINDICATIONS

1. Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy, or with a past history of these conditions.
2. Patients with markedly impaired liver function.
3. Patients with known or suspected carcinoma of the breast.
4. Patients with known or suspected estrogen-dependent neoplasia.
5. Undiagnosed abnormal genital bleeding.

WARNINGS

1. The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately.

Studies conducted in Great Britain and reported in April 1968 estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and nonusers were highly significant.

The conclusions reached in the studies are summarized in the table below:

COMPARISON OF MORTALITY AND HOSPITALIZATION RATES DUE TO THROMBOEMBOLIC DISEASE IN USERS AND NONUSERS OF ORAL CONTRACEPTIVES IN BRITAIN

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Ages 20-34	Ages 35-44	Ages 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Nonusers	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be directly applied to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may be different.

2. Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

3. Since the safety of oral contraceptives in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period.

4. A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

PRECAUTIONS

1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear.

2. Endocrine and possibly liver function tests may be affected by treatment with oral contraceptives. Therefore, if such tests are abnormal in a patient taking an oral contraceptive, it is recommended that they be repeated after the drug has been withdrawn for 2 months.

3. Under the influence of estrogen-progestogen preparations, preexisting uterine fibromyomata may increase in size.

4. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

5. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic measures are indicated.

6. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree.

7. Any possible influence of prolonged oral contraceptive therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

8. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving oral contraceptive therapy.

9. Because of the effects of estrogens on epiphyseal closure, oral contraceptives should be used judiciously in young patients in whom bone growth is not complete.

10. The age of the patient constitutes no absolute limiting factor, although treatment with oral contraceptives may mask the onset of the climacteric.

11. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.

ADVERSE REACTIONS OBSERVED IN PATIENTS RECEIVING ORAL CONTRACEPTIVES

A statistically significant association has been demonstrated between use of

oral contraceptives and the following serious adverse reactions:

- Thrombophlebitis
- Pulmonary embolism

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions:

- Cerebrovascular accidents
- Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis

The following adverse reactions are known to occur in patients receiving oral contraceptives:

- Nausea
- Vomiting
- Gastrointestinal symptoms (such as abdominal cramps and bloating)
- Breakthrough bleeding
- Spotting
- Change in menstrual flow
- Amenorrhea during and after treatment
- Edema
- Chloasma or melasma
- Breast changes: tenderness, enlargement and secretion
- Change in weight (increase or decrease)
- Changes in cervical erosion and cervical secretions
- Suppression of lactation when given immediately postpartum
- Cholestatic jaundice
- Migraine
- Rash (allergic)
- Rise in blood pressure in susceptible individuals
- Mental depression

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted:

- Anovulation post-treatment
- Premenstrual-like syndrome
- Changes in libido
- Changes in appetite
- Cystitis-like syndrome
- Headache
- Nervousness
- Dizziness
- Fatigue
- Backache
- Hirsutism
- Loss of scalp hair
- Erythema multiforme
- Erythema nodosum
- Hemorrhagic eruption
- Itching

The following laboratory results may be altered by the use of oral contraceptives:

- Hepatic function: Increased sulfobromophthalein and other tests
- Coagulation tests: Increase in prothrombin Factors VII, VIII, IX, and X
- Thyroid function: Increase in PBI and butanol extractable protein-bound iodine, and decrease in T³ uptake values
- Metyrapone test
- Pregnanediol determination

SYNTEX
SYNTEX LABORATORIES, INC.
PALO ALTO, CALIFORNIA 94304



Should we put Novahistine Expectorant in funny-looking bottles?

We were kids ourselves once. That's why we're always thinking of ways to make Novahistine® Expectorant more appealing to your young patients.

On the other hand, medicine is medicine. And it has to work. We never forget that. You'll find that Novahistine Expectorant doesn't have to come in funny-looking bottles to get where it needs to go. And you'll find that it is particularly well-tolerated and effective in liquefying tenacious exudates and encouraging expectoration in the young patient suffering bronchitis. In addition, it provides decongestant action and controls the cough. Each 5-ml. teaspoonful of Novahistine Expectorant decongestant-antitussive contains

codeine phosphate, 10 mg. (warning: may be habit-forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; glyceryl guaiacolate, 100 mg.; chloroform, 13.5 mg.; l-menthol, 1 mg.; alcohol 5%.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Continuous dosage over an extended period is contraindicated, since codeine phosphate may cause addiction.

PITMAN-MOORE Division of
The Dow Chemical Company, Indianapolis





You've made it one of your specific in acute otitis media

DECLOMYCIN acts against many strains of *H. influenzae*, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

You've found the high serum levels of DECLOMYCIN important, too. Its prolonged action permits convenient 300 mg b.i.d. or 150 mg q.i.d. administration.

When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanel has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium containing drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

DECLOMYCIN
DEMETHYLCHLORTETRACYCLINE

LEDERLE LABORATORIES, A Division of
American Cyanamid Company, Pearl River, New York





You've made it one
of your specifics in acute otitis media

DECLOMYCIN
DEMETHYLCHLORTETRACYCLINE

A specific solution for tinea versicolor

Although tinea versicolor is not a serious disease it is chronic and recurrent and specific treatment is cosmetically important. "Of the wide variety of compounds recommended for the treatment of tinea versicolor, sodium thiosulfate still remains the standard."^{*} However, when sodium thiosulfate is administered alone it decomposes rapidly and produces an offensive odor. These disadvantages have been largely eliminated by the development of TINVER Lotion, which contains sodium thiosulfate and salicylic acid in MICEL A[®] base.[†]

TINVER—the likable lotion for tinea versicolor—is clinically effective, cosmetically acceptable, and easy to apply. It produces rapid, visible improvement without the objectionable features of oily pastes and odorous solutions. Patient acceptability encourages continued therapy without interruption. TINVER is

practical and economical for long-term therapy.

Indications: For topical use in the treatment of tinea versicolor.

Precautions: If signs of irritation or sensitivity develop, discontinue use. Do not use on or about the eyes.

Dosage and Administration: Thoroughly wash, rinse, and dry the affected area before applying medication. Apply a thin film of the lotion twice a day, or as directed. Although diagnostic evidence of the tinea versicolor may disappear in a few days, it is advisable to

continue treatment for a much longer period. Clothing should be boiled to prevent reinfection.

Supply: 5 oz. polyethylene squeeze bottle.

^{*}McClarin, W. M., and Knox, J. M.: *Cutis* 3:619 (June) 1967.

[†]The MICEL A[®] base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.



Tinver[®] Lotion

Sodium thiosulfate USP 25%, salicylic acid USP 1%, isopropyl alcohol NF 10%, and propylene glycol USP, in a MICEL A base of menthol USP, disodium edetate, colloidal alumina, and purified water USP.



BARNES-HIND LABORATORIES

Subsidiary of Barnes-Hind Pharmaceuticals, Inc.
Sunnyvale, Calif. 94086



Amfac Salutes "Pina"

After forty five years of perfect service, Manuel Pina, our "director of transportation" is retiring. It's going to be a bit hard for us without "Pina's" smiling face there every day. Because in those forty five years "Pina" has become almost a legend to Hawaii's medical community. Rain or shine, he always has a friendly word, a helping hand.

It's going to be a bit different without "Pina" around at first. He'll be out in front of his place at Hauula fishing and taking it easy in the sun. But we do have one consolation: "Pina" has promised to come back and help out during the summer. So, although we'll be missing him for a while — "Pina" will be back again in the summers. So, fortunately, we don't have to say goodbye. We'll just tip our hat with pride, and look forward to seeing Pina this summer.

AMFAC DRUG DEPARTMENT



AMFAC INC



REMINDER: Your Patients' HMSA Protection Protects You!

Both you and your patients welcome the economic security that comes with HMSA protection.

We hope you will remind unprotected patients that HMSA individual enrollments are accepted three months a year, during

MARCH JULY NOVEMBER

HMSA is a completely non-profit community service association that provides tremendous benefits for reasonable dues and offers free choice of doctors and hospitals. All ages accepted.

HAWAII-OWNED FOR HAWAII'S OWN



BLUE SHIELD PLAN
FOR HAWAII

Member of Western
Conference of Prepaid
Medical Service Plans

**HAWAII
MEDICAL
SERVICE
ASSOCIATION**

Public Enema No.1



from the rewards of sparing your patients the tubes and tribulations of unpleasant enemas.

Compared to enemas, Dulcolax suppositories are a simpler and simpler way to empty the bowel. Gone are the tubing, the "accidents", and the bruised egos. One suppository, inserted against the bowel wall, usually brings about an evacuation within 15 minutes or an hour.

In the hospital, order Dulcolax for constipation or

bowel cleansing. Your patients will often prefer it to embarrassing enemas. And you can be sure nurses will appreciate the saving in time and effort.

Dulcolax tablets taken at night usually result in a bowel movement the following morning. A combination of tablets at night and a suppository the next morning generally cleans the bowel thoroughly in preparation for surgery or special procedures. Keep in mind, however, that the drug is contraindicated in the acute surgical abdomen.

Dulcolax®...it's predictable
bisacodyl



So he'll breathe easier: relieve anxiety while you relieve pain.

Relief of pain is usually a major goal in traumatic conditions. But often of importance, too, is alleviation of anxiety and tension that may heighten patient discomfort.

Single-prescription, non-narcotic Equagesic may effectively relieve pain. And ease anxiety and tension.

TABLETS

Equagesic[®]

(meprobamate and ethoheptazine
citrate with aspirin)



IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: **USE IN PREGNANCY:** Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

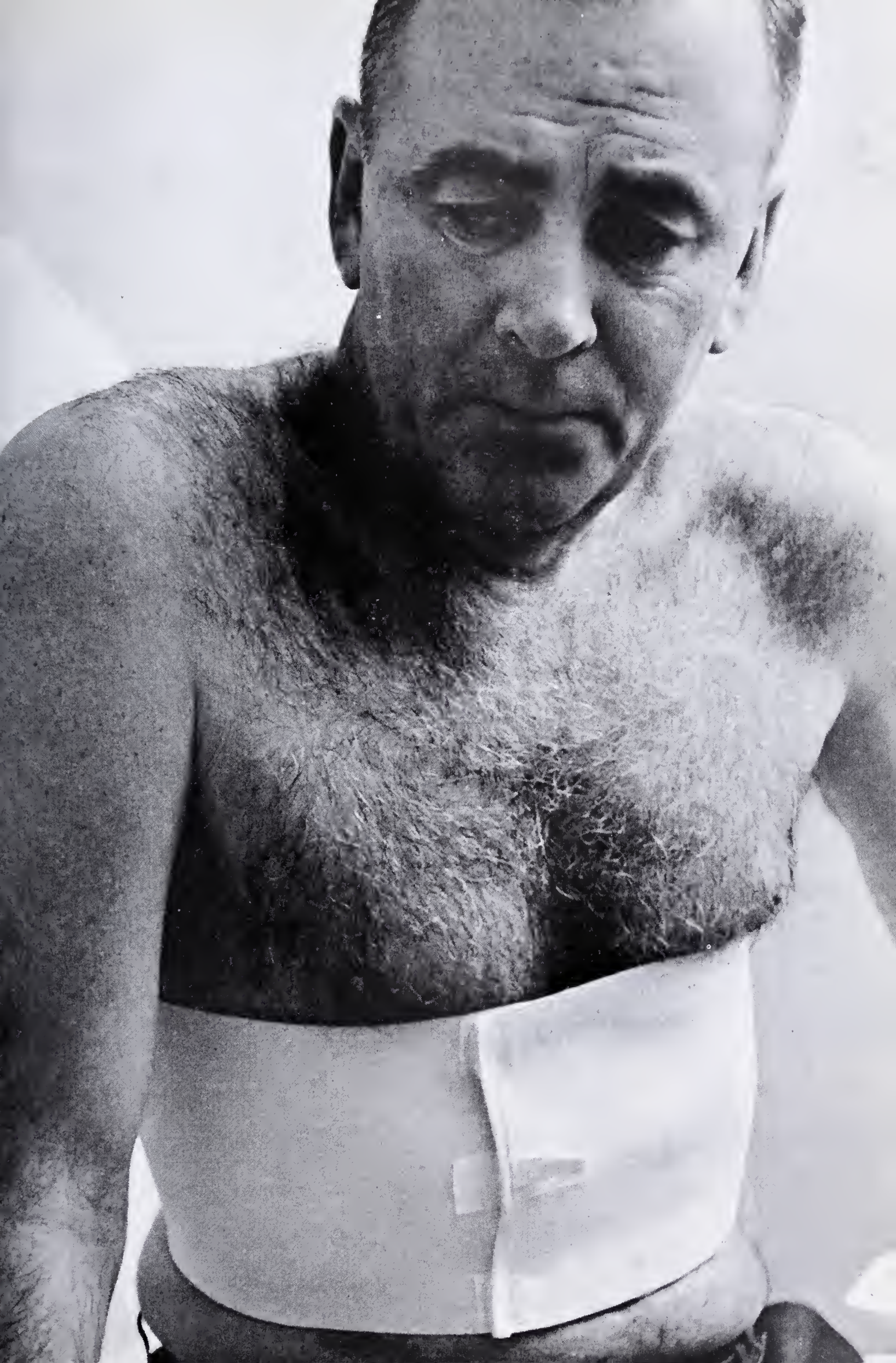
Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

Wyeth Laboratories Philadelphia, Pa.

Photo professionally posed.





*“For all the happiness
mankind can gain
It is not in pleasure,
but in rest from pain.”*

John Dryden

Empirin® Compound with Codeine Phosphate gr. 1/2 No. 3

Each tablet contains: Codeine Phosphate gr. 1/2 (Warning—May be habit forming), Phenacetin gr. 2 1/2, Aspirin gr. 3 1/2, Caffeine gr. 1/2.

gives your patient rest from pain

*B.W. & Co.' narcotic products are Class "B", and as such are available on oral prescription, where State law permits.



BURROUGHS WELLCOME & CO.(U.S.A.)INC., Tuckahoe, N.Y.

Carnation

EVAPORATED MILK

**HAWAII'S HEALTHY BABY
MILK...**

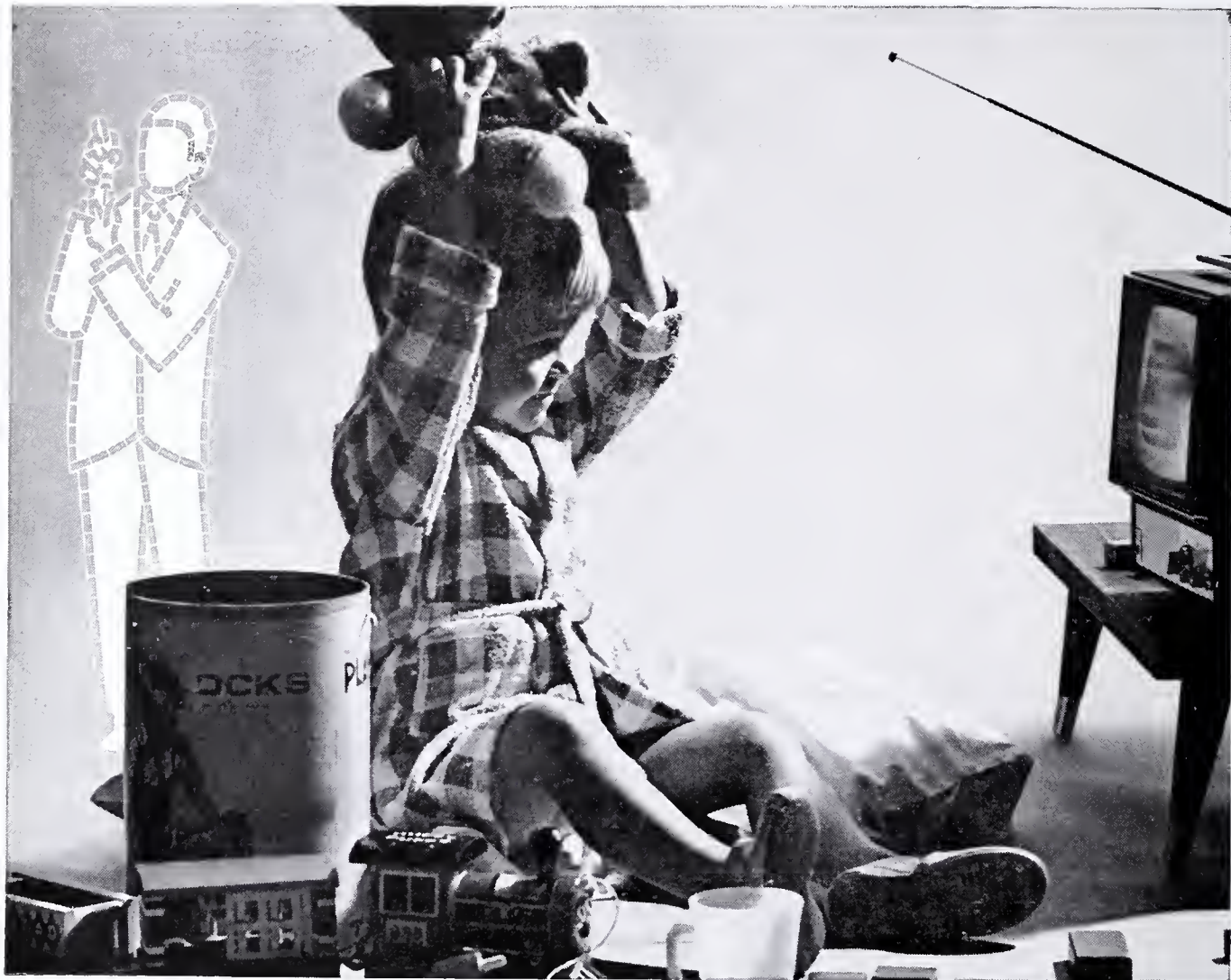


"from Contented Cows"

1st CHOICE FOR INFANT FEEDING...
No. 1 in the Islands for generations,
...available everywhere in Hawaii

1966
Carnation Healthy Baby Contest
\$1,000 1st prize winner,
Peter David Keaomalalama Yoshimi Malo
of Honolulu, Hawaii

It's almost as if you were there to give an injection of penicillin



V-Cillin K[®], Pediatric dependable oral penicillin therapy

Potassium Phenoxyethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin[®] (phenoxyethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

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*Pyloric stenosis in Hawaii is about the same as in other localities,
it seems. We don't diagnose or treat it as skillfully, however.*

Pyloric Stenosis in Hawaii: A 25-Year Survey of 276 Cases

I. Clinical Aspects

WALTON K. T. SHIM, M.D.,* ANNE CAMPBELL, B.A.,†
and STANLEY WRIGHT, M.D.,‡ Honolulu

● *Male infants with pyloric stenosis outnumber females by 5:1, in Hawaii as elsewhere. In two out of three, a pyloric tumor can be felt and roentgen examination is unnecessary for diagnosis. Birth weights of affected infants are significantly higher than normal. In this study, mucosal perforation occurred at operation in 29 per cent, and infections occurred in 6.5 per cent.*

METHODS

Data were obtained from 16 hospitals on 276 patients operated upon for pyloric stenosis over a 25-year period, 1942-1966 (Table 1). All charts were studied for: (1) sex, (2) palpability of the tumor, (3) gastric waves, (4) roentgen signs, (5) age at operation, (6) complications, and (7) mortality. Birth weights were obtained from birth certificates. Index cases were matched with their birth certificates by the CDC 3100 computer, and weights for 317,015 unaffected infants born during

THE INTRODUCTION of pyloromyotomy by Dufour and Fredet in 1908¹ and Ramstedt in 1912² led to uniformity in the surgical treatment of pyloric stenosis. Early surgery with emphasis on preoperative fluid and electrolyte replacement has produced a gratifying decrease in mortality and morbidity. The present study was undertaken to evaluate the management of this disease in Hawaii. Treatment has been carried out in various hospitals by different surgeons, in contrast to most published studies where a limited number of surgeons have operated upon all cases.

TABLE 1.—Identification of Patients.

ISLAND	HOSPITAL NAME	YEARS	NUMBER OF PATIENTS
Oahu	Queen's Hospital	1947-1966	19
	St. Francis Hospital	1944-1966	14
	Tripler Military Hosp.	1948-1966	125
	Kaiser Foundation Hosp.	1958-1966	11
	Leeward General (Aiea)	—	0
	Wahiawa General Hosp.	1957-1966	0
	Castle Memorial Hosp.	—	0
	Kuakini Hospital	1944-1966	2
Kauai	Kauaikeolani Children's	1942-1966	88
Kauai	Kauai Veteran's Hosp.	1955-1966	1
	Wilcox Memorial Hosp.	1942-1966	2
Maui	Maui Memorial Hospital	1956-1966	5
Hawaii	Hilo Memorial Hospital	1950-1966	9
	Kona Hospital	—	0
	Kohla Hospital	—	0
	Honokaa Hospital	—	0
TOTAL NUMBER OF PATIENTS			276

From the Kauaikeolani Children's Hospital Department of Surgery and the Department of Genetics, University of Hawaii. Received for publication June 18, 1968.
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TABLE 2.—*Presence of Palpable Pyloric "Tumor."*

	PATIENTS	PER CENT
Tumor palpable	170	65
Tumor not palpable	91	35
TOTAL	261*	100

* For 15 patients the presence or absence of a pyloric "tumor" could not be determined.

this time and the 252 affected infants were obtained. Data on birth order, racial incidence, family history, and genetic aspects will be presented in later publications.³

The criterion for the final diagnosis of pyloric stenosis was the presence of a pyloric "tumor" at surgery. Vomiting in infants is so common that a diagnosis of pyloric stenosis in an infant admitted for vomiting, but not operated upon, would be suspect. A deficit in this study is that there is no way to know how many patients had clinical evidence for pyloric stenosis but normal findings at surgery.

RESULTS

Sex incidence: Two hundred twenty-eight of the 276 patients were males, a male:female ratio of 5:1, which is similar to other series.^{4, 5, 6}

Physical examination: A "tumor" on physical examination was "palpable" or "not palpable." A "questionably palpable" tumor was considered not palpable. Of 261 patients, a "tumor" was felt in 170 (65 per cent). Presence or absence of a "tumor" could not be determined in 15 cases (Table 2).

Gastric waves were present in 104 (52 per cent) of 200 patients and absent in 96. Their presence or absence was not stated in 76 cases (Table 3).

TABLE 3.—*Gastric Waves.*

	PATIENTS	PER CENT
Present	104	52
Absent	96	48
TOTAL	200*	100

* For 76 patients no mention was made of presence or absence of gastric waves.

Roentgen examination: The results of the roentgen examination were based on the report in the patient's chart. An examination considered to be diagnostic of pyloric stenosis is defined as one in which a "string sign" or an indentation from a pyloric "tumor" was present, or in which the report stated "hypertrophic pyloric stenosis," even though no details of the study were given. Delayed emptying without the signs noted above was not considered diagnostic.⁷ Based on these criteria, 70 per cent of 191 roentgen studies were diagnostic of pyloric stenosis (Table 4).

TABLE 4.—*Results of Roentgen Examination.*

	CASES	PER CENT
Diagnostic	133	70
Not diagnostic	58	30
TOTAL	191*	100

* No roentgen studies were performed on 85 patients (or results were not recorded).

The percentages of diagnostic physical and roentgen examinations do not significantly differ, being 65 and 70 per cent respectively.

It is pertinent that 74 per cent of the 91 patients who had no palpable tumor (Table 2) had roentgen studies performed, while 71 per cent of 170 patients with palpable tumors also had roentgen examinations. Thus, whether physical examinations revealed a "tumor" or not, a roentgen study was often unnecessarily obtained (Table 5).

TABLE 5.—*Comparison of Patients With and Without Palpable Tumors Receiving Barium Study.*

	CASES	NUMBER HAVING BARIUM STUDY	PER CENT
Without palpable tumor	91	67	74
With palpable tumor	170	121	71
TOTAL	261	188	72

Age at surgery: There were 259 full-term infants and seven prematures (prematurity was defined as less than 38 weeks gestation and a birth weight of less than five pounds). The modal age at surgery for the full-term infants was five weeks. Although the group of prematures is too small for significant comparison, it is of interest that its modal age at surgery was seven weeks.

Birth weight: The average weight of 252 affected infants was 7.34 lb while that of the total sample of 317,015 infants was 7.03 lb (Table 6). The 0.31 lb difference is significant at the 0.1 per cent level and includes all "pure" and mixed infants. Only the affected Caucasian and Japanese groups were large enough for valid statistical weight comparison, but similar differences in weight were found. The affected infants were 0.35 and 0.22 lb heavier, respectively ($p < 0.001$). Because Caucasian babies are heavier than Japanese, we com-

TABLE 6.—*Birth Weight and Pyloric Stenosis.**

GROUP	NONAFFECTED NUMBER	AV. WT.	AFFECTED NUMBER	AV. WT.	WEIGHT DIFFER- ENCE
All infants	317,015	7.03 lb.	252	7.34 lb.	+0.31 lb.
Caucasian	83,257	7.22	157	7.57	+0.35
Cauc.-Jap.	6,948	7.07	6	7.36	+0.29
Japanese	73,015	6.91	43	7.13	+0.22

* Using multiple regression analysis, controlling the variation due to year of birth, maternal age, birth order, sex and race, birth weight was positively correlated with pyloric stenosis, $p < .001$.

pared infants of mixed Caucasian-Japanese parentage and found the average weights of both the affected and nonaffected mixed groups to lie midway between the weights of pure Caucasian and pure Japanese infants. The average birth weight for the seven premature infants was 4.06 lb with a range of 2.75 to 4.81 lb.

Operative procedures: Two hundred seventy-five patients had a Fredet-Ramstedt pyloromyotomy and one an exploratory duodenotomy as an initial procedure. Four patients had multiple procedures. One of these was the infant who had the duodenotomy. A gastrojejunostomy was performed one week later, but he died of peritonitis. Another patient had three procedures—pyloromyotomy, exploratory laparotomy with passage of a duodenal tube, and finally a gastrojejunostomy. This patient is now doing well at 15 years of age. The third patient had two pyloromyotomies, the first of which had closed with scar tissue. The fourth patient had a pyloromyotomy with closure of a perforation, but continued to show signs of obstruction. On re-exploration he had an intra-abdominal abscess over the pylorus, and peritonitis. This patient subsequently died.

Mortality: There were four postoperative deaths among the 276 infants for a mortality rate of 1.45 per cent. Two of these patients are noted above. The third patient was a premature infant who died of aspiration pneumonia, and the fourth infant died of an unknown cause.

Complications: (Table 7).

- **Perforations:** From 224 records it was possible to determine that there had been a mucosal perforation in 66 instances (29 per cent).
- **Infections:** There were 18 infections: 16 infants had wound infections, one had an intra-abdominal abscess and peritonitis, and one had generalized peritonitis. The infection rate was 6.5 per cent. If the one infection following gastrojejunostomy is excluded, there were 17 infections with pyloromyotomy. In three of these, mucosal perforation at surgery could not be ascertained, seven were preceded by perforation, and seven occurred without perforation. The occurrence of seven infections following 66 perforations is not significantly different from seven infections in 158 patients in whom perforation did not occur ($0.1 < p < 0.2$).

Two wound infections, preceded by perforations, developed subsequent incisional hernias. In an additional patient, a dehiscence occurred following a mucosal perforation, but without wound infection.

- **Postoperative vomiting:** Although vomiting is occasionally projectile in nature, it is not so severe in force and amount as that which occurs preoperatively. Frequently, it lasts for several days. Of the 212 charts evaluated, 29 per cent had no vomiting, and 71 per cent vomited postoperatively.

TABLE 7.—Summary of Complications in Pyloric Stenosis.

COMPLICATION	CASES	PER CENT
Perforation (224 records)	66	29
Infections:	18	6.5
Wound infections	16	
Intra-abdominal abscess	1	
Peritonitis	1	
Incisional hernia	2	
Dehiscence	1	
Postoperative vomiting (212 records)		
Absent	61	29
Present:	151	71
Under 48 hours	58	27
Over 48 hours	93	44
Reoperations	4	
Anesthetic	2	
Sepsis	1	

See text for explanation.

Twenty-seven per cent vomited only during the first 48 hours, and 44 per cent vomited for more than 48 hours.

- **Anesthetic.** One patient aspirated during mask anesthesia, indicating the necessity for intubation when the stomach is to be manipulated. Another patient who had no preoperative medication suffered a cardiac arrest during induction, but was successfully resuscitated, and underwent pyloromyotomy without further incident immediately following the arrest.

- **Sepsis.** One patient developed sepsis following pyloromyotomy, but recovered with therapy.

DISCUSSION

A review of 276 cases of hypertrophic pyloric stenosis in Hawaii has revealed similarities with as well as differences from other studies. While complications of surgery, e.g. mucosal perforations, seem to be more frequent in Hawaii, the mortality rate of 1.45 per cent is not significantly different from the rate in large medical centers on the mainland. Benson,⁵ Gross,⁸ and Donovan⁶ have reported mortality rates of less than one per cent. Gordon *et al*⁹ had a mortality rate of 1.78 per cent in 1,573 cases.

A palpable pyloric tumor in an infant with projectile, nonbilious vomiting is pathognomonic of pyloric stenosis. Once the pyloric "tumor" is palpated, the added expense and radiation exposure of a roentgen examination to confirm a diagnosis made on clinical examination is not warranted.

The higher birth weights of those infants affected by pyloric stenosis has previously been described by Malmberg.¹⁰ However, the difference has not before been quantitated for statistical analysis. The meaning of this weight difference is not clear, but does tend to indicate that there is some congenital difference between those affected and those who are not.

The frequency of perforation was 29 per cent. Most authors report a two to ten per cent perforation rate.^{8, 9, 11, 12, 13, 14} The incidence of infections was 4.4 per cent in those without perforation but 11 per cent in those with perforation. Although the difference is not statistically significant ($p>0.1$), a correlation is suggested. We feel that an attempt should be made to maintain mucosal integrity. Our experience differs from that of Miller,¹² who had three wound infections, none of which followed perforation, in 87 cases.

The incidence of postoperative vomiting, 71 per cent, is similar to the 79 per cent of Miller,¹² but is greater than the 35 per cent reported by Rheinlander and Swenson.¹³ Benson⁵ states that about half his cases "spit up" following surgery, but felt that persistent postoperative vomiting is rare. The frequency of postoperative vomiting may be a reflection of the care with which the nurses' notes are scrutinized. Nevertheless, the frequency of vomiting is great enough to warrant informing parents that it may be expected postoperatively.

Reoperations for continued obstruction were performed in only four patients, though many had significant postoperative vomiting. This figure is comparable to those reported by others.^{8, 9, 11, 12, 13, 14}

The clinical records of 276 patients with pyloric stenosis have been reviewed. The male:female ratio of 5:1 is similar to the ratio in other series. The mortality rate of 1.45 per cent is also similar to reported rates from the mainland.

The palpability of "tumors" was 65 per cent; positive roentgen studies were found in 70 per cent of patients. In those instances where a pyloric tumor has been palpated, roentgen examination adds only expense and radiation exposure to an infant in whom a clinical diagnosis has been made.

A significantly higher birth weight was noted for those affected with pyloric stenosis, but its meaning is not understood.

The frequency of operative mucosal perforation (29 per cent), and total infections (6.5 per cent) was higher than for other studies. The infection rate following perforation was 11 per cent, and 4.4 per cent in cases without perforation. Postoperative vomiting occurred in 71 per cent of patients.

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REFERENCES

1. Dufour, H., and Fredet, P.: La stenose hypertrophique du pylore chez le nourisson et son traitement chirurgical, *Rev. Chir. Orthop.*, 37:208, 1908.
2. Ramstedt, C.: Zur Operation der Angeborenen Pylorus-stenose, *Med. Klin.* 8:1702, 1912.
3. Shim, W. K. T., Campbell, Anne, and Wright, S. W.: Unpublished data.
4. Pollock, W. F., Norris, W. J., and Gordon, H. E.: The management of hypertrophic pyloric stenosis at the Los Angeles Children's Hospital. A review of 1,422 cases, *Amer. J. Surg.*, 94:335 (Aug.) 1957.
5. Benson, C. D., and Lloyd, J. R.: Infantile pyloric stenosis, *Amer. J. Surg.*, 107:429 (March) 1964.
6. Donovan, E. J.: In comments on a paper by D. E. Robertson, *Ann. Surg.*, 112:695 (Oct.) 1940.
7. Caffey, J.: *Pediatric X-ray Diagnosis*, Yearbook Medical Publisher, pp. 561, 1961 (4th Ed.).
8. Gross, R. E.: *The Surgery of Infancy and Childhood*, Philadelphia: W. B. Saunders, 1953.
9. Gordon, H. E., *et al*: Hypertrophic pyloric stenosis: experience with 1,573 cases at Los Angeles Children's Hospital, *Western J. Surg.*, 67:139 (May-June) 1959.
10. Malmberg, N.: Hypertrophic pyloric stenosis—a survey of 136 successive cases—with special reference to treatment with Scopyl, *Acta paediat.*, 38:472-483, 1949.
11. Grimes, O. F.: Congenital hypertrophic stenosis, *J. Pediat.* 37:522 (Oct.) 1950.
12. Miller, D. R., and Friesen, S. R.: Hypertrophic pyloric stenosis: a clinical analysis of 87 cases with special reference to etiologic factors, *Amer. Surg.*, 22:108 (Jan.) 1956.
13. Rheinlander, H. F., and Swenson, O.: The diagnosis and management of congenital hypertrophic pyloric stenosis, *J. Pediat.*, 41:314 (Sept.) 1952.
14. Savage, J. L.: Congenital hypertrophic pyloric stenosis, *Quarterly Bulletin, Northwestern University Medical School*, 29:236, 1955. ■

Have a Heart—
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*Diabetes insipidus of nephrogenic origin is recorded
in four members of a family, for the first time in Samoans.*

Familial Nephrogenic Diabetes Insipidus

KENNETH K. NAKANO, M.D., *Boston*

● *Four cases of vasopressin-resistant, nephrogenic diabetes insipidus were discovered in a Samoan family; transmission from grandmother to grandchildren was via a heterozygous woman carrier. This is the first report of this disease in a Samoan pedigree, and the first report of this disease in Hawaii.*

Early attention to fluid balance problems is essential, in this disease, if severe polyuria, polydipsia, and mental retardation are to be prevented.

THE FIRST family study of nephrogenic diabetes insipidus in Hawaii is presented, and this rare entity is found to be transmitted by Samoan heterozygous women carriers.

CASE STUDIES

Case 1: An obese, 23-year-old, gravida 4, para 3, Samoan-Caucasian woman was seen in the antepartum clinic on May 16, 1968, where an examination revealed an intrauterine pregnancy of 20 weeks; otherwise, the physical examination was normal. Her urine had a specific gravity of 1.004 and a pH of 6.0; tests for albumin, glucose, and ketones were negative; there were 0-1 WBC's, 2-4 RBC's, but no casts or crystals. A subsequent 24-hour urine collection yielded 6,500 cc of a clear, sugar-free urine with a specific gravity of 1.005.

The maternal grandmother, the patient's 17-year-old brother, and her 15-year-old sister, in addition to the two sons of the patient, were said to have severe polyuria and polydipsia (Fig. 1). The 61-year-old pure Samoan maternal grandmother was hospitalized on March 8, 1968, and noted to have polydipsia, polyuria, and a urine specific gravity of 1.006 despite a fever of 102°F. and dehydration secondary to *Shigella B* dysentery. She was treated with intravenous fluids and ampicillin with marked clinical improvement; however, the patient continued to have polydipsia and polyuria. Case 1's mother, the asymptomatic

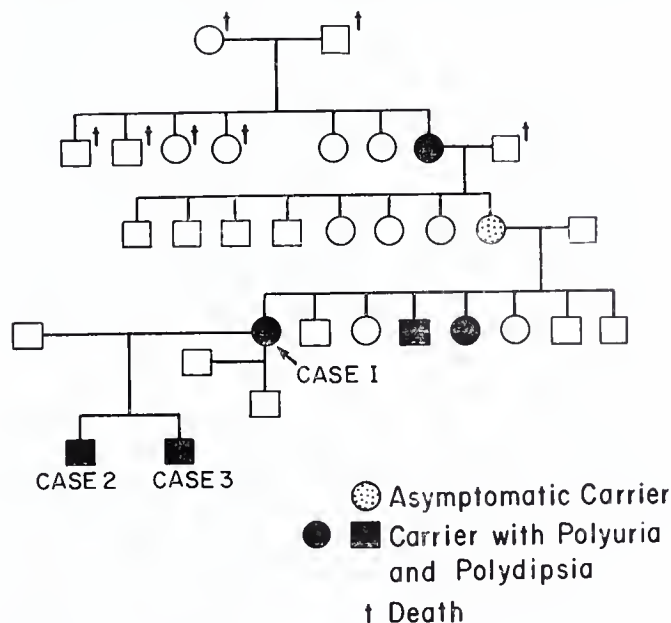


FIG. 1.—The Samoan pedigree.

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TABLE 1.—Summary of laboratory findings in Cases 1 and 2.

	CASE 1	CASE 2
Hematocrit	36 per cent	32 per cent
2-hr p.c. blood sugar	82 mg/100 ml	85 mg/100 ml
BUN	5 mg/100 ml	4 mg/100 ml
Creatinine clearance	98 ml/min/1.73m ²	100 ml/min/1.73m ²
Sodium	138 mEq/L	139 mEq/L
Potassium	3.9 mEq/L	4.9 mEq/L
Chloride	106 mEq/L	103 mEq/L
PPD skin test	negative	negative
VDRL	negative	negative
T ₄ (thyroxine)	6.5 mcg/100 ml	7.0 mcg/100 ml
Plasma cortisol		20 mcg/100 ml
24-hr urine		
17-ketosteroids (Zimmerman reaction)	10 mg/24 hr	5 mg/24 hr
17-hydroxy-corticosteroids (borohydride reduction)	22 mg/24 hr	8 mg/24 hr

carrier, transmitted the disease to Case 1 who, in turn, transmitted the disease to her youngest sons (i.e., Case 2 and Case 3). Case 3, the second of three boys born to Case 1, was hospitalized in another hospital at age six months (1965) where a diagnosis of "nephrogenic diabetes insipidus" was made based on the following: (1) polyuria (average of 2,500 cc per day) with persistently low urine specific gravities (range between 1.000 and 1.003); (2) hypernatremia (as high as 160 mEq/l); and (3) resistance to vasopressin. At age 3 years, 6 months, the patient continued to have polydipsia, polyuria, hypotonic urine, and recurrent elevations of temperature. Case 2, the youngest of Case 1's three boys, was found to have vasopressin-resistant diabetes insipidus at the same time as Case 1.

Case 1 was hospitalized for 12 days and the fluid intake varied between 2,400 cc (during fluid restriction) and 8,600 cc per 24 hours; the urinary output ranged between 3,400 cc and 12,000 cc per 24 hours. The urine was persistently of a

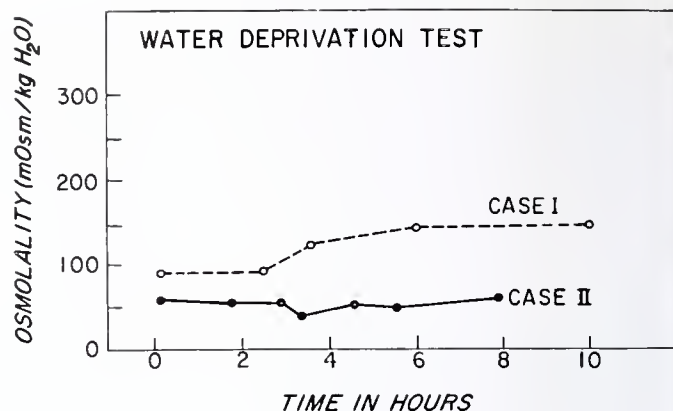


FIG. 2.—Water deprivation test. Prolonged fluid restriction did not significantly increase the urine osmolality in either patient.

light color and the specific gravity varied between 1.002 and 1.006. Various laboratory tests were normal (Table 1). Roentgenograms of the chest and EKG were normal. Skull roentgenograms did not show enlargement of the sella turcica.

A water deprivation test over a ten-hour period was conducted on the second hospital day; and after this period of fluid deprivation, the urine osmolality rose to only 151 mOsm/kg H₂O (following a fluid restriction test the urine concentration should normally be at least 850 mOsm/kg H₂O) (Fig. 2). On the fifth hospital day a pitressin test was performed using 0.3 ml/m² of aqueous pitressin intramuscularly, and after six hours 0.6 ml/m² was injected. Before, during, and after a six- to eighteen-hour period the patient was unable to produce a concentrated urine (Fig. 3). Finally, after a sufficient water load had been given, a hypertonic saline test (Hickey-Hare¹) was done on the sixth hospital day using a three per cent saline solution intravenously at 0.25 ml/kg/min over a 45-minute period (Fig. 3). The hypertonic

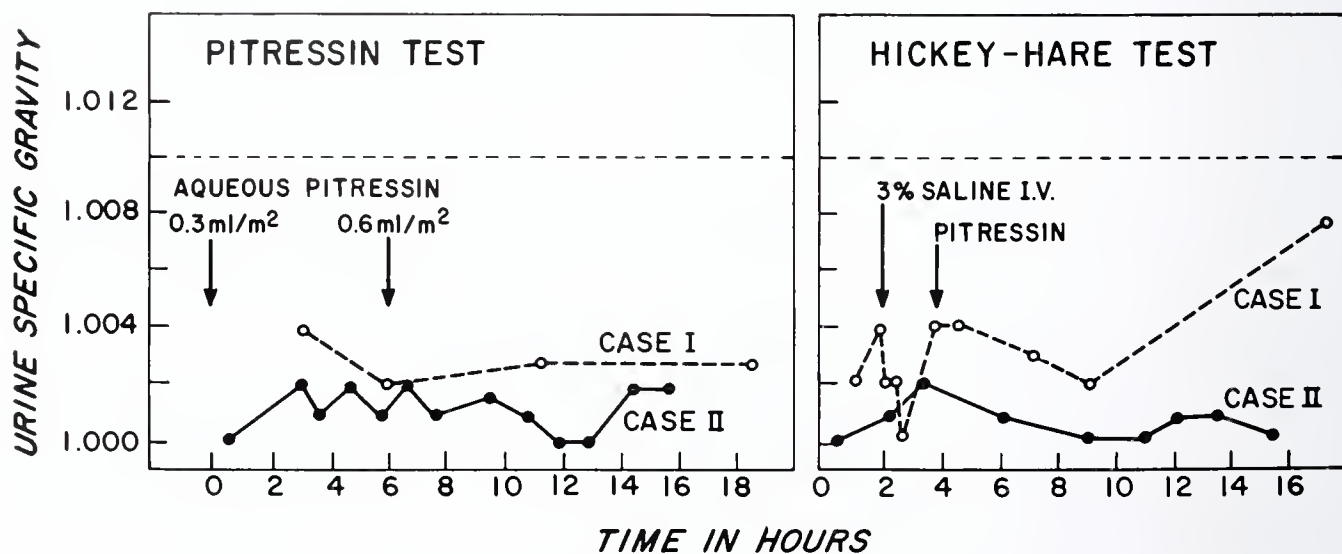


FIG. 3.—Pitressin and Hickey-Hare test. Parenteral pitressin failed to produce an antidiuretic response in either patient.



FIG 4.—Case 2: Characteristic activity.

saline test failed to produce an antidiuretic response or hypertonic urine, and, in combination with the resistance to parenteral pitressin, indicated that the patient had a vasopressin-resistant form of diabetes insipidus.

Case 2: A 1-year, 9-month-old Samoan-Caucasian-Hawaiian boy was hospitalized because of a temperature of 105°F. and dehydration. Urine specific gravity was 1.002. Except for imbibing large quantities of water and urinating frequently since birth, the child's birth history and health were stated to be normal.

Physical examination revealed an irritable, febrile boy with poor skin turgor and a slightly distended abdomen (Fig. 4). His rectal temperature was 105°F., his pulse 140 per minute, his respirations 30 per minute, and his blood pressure 100/60. His head circumference was 47 cm, his height was 73.5 cm, and his weight was 9.1 kg. His oropharynx was reddened, and his neck was supple and without thyromegaly. The posterior cervical lymph nodes were enlarged bilaterally. On auscultation of the child's lungs there were heard rales on the left side; heart rate was 140 beats per minute. His abdomen was distended and a

2X3 cm umbilical hernia was noted; in addition, the abdominal veins were prominent. Neurological evaluation was normal and the child had normal genitalia for his age.

Urinalysis yielded a straw colored, clear urine with a pH of 5.5, specific gravity of 1.002; tests for albumin and ketones were negative; there were no WBC's 1-2 RBC's, and no casts. Numerous repeat urinalyses have shown a low specific gravity (range between 1.000 and 1.005) and negative for glucose. Roentgenograms of the chest revealed an infiltrate in the left upper lobe; and a throat culture produced pneumococci. However, five days after intramuscular penicillin therapy, the x-ray films showed clearing of this infiltrate. Skull x-rays and an EEG were normal. Likewise, various laboratory tests were normal (Table 1). An IVP demonstrated bilateral function of the kidneys and ureters. Roentgenograms of the wrist bones were taken to determine the bone age of the patient, and revealed two carpal bones which satisfied the criteria for a bone and chronological age of two years.

The child's daily oral intake varied between 2,500 cc (a day of fluid restriction) and 5,500 cc, and his urine output ranged from 2,400 cc to 5,300 cc per 24 hours, while the specific gravity of the urine never rose above 1.006 during the 14 days in the hospital. A water deprivation test was conducted on the third hospital day; and after eight hours of fluid restriction the urine osmolality increased to only 64 mOsm/kg H₂O (Fig. 2). On the fifth hospital day a pitressin test was performed and 0.3ml/m² of aqueous pitressin was given intramuscularly. Even after 0.6 ml/m² was injected, when the patient complained of abdominal cramps, nausea and a warm sensation (side effects of high doses of pitressin) the child continued to have polydipsia, polyuria, and urine of low specific gravity and osmolality (Fig. 3). A hypertonic saline test (Hickey-Hare) was done on the eighth hospital day, using 3 per cent saline intravenously at 0.25 ml/kg/min over a 45-minute period. There was no antidiuretic response after the Hickey-Hare test, and because of polydipsia and polyuria associated with a hypotonic urine which was not benefited after parenteral pitressin, the conclusion was that this patient had vasopressin-resistant diabetes insipidus.

DISCUSSION

The case studies that have been presented represent familial vasopressin-resistant diabetes insipidus which is manifested as a dominant sex-linked disorder with variable expressivity in the heterozygous female as described by Orloff and Walser.² Case 1 and her two youngest sons have severe polydipsia and polyuria associated with a hypo-

tonic urine which is unresponsive to fluid restriction, hypertonic saline or vasopressin which, in turn, is suggestive of nephrogenic diabetes insipidus. Case 1 had always complained of an insatiable thirst and persistent polyuria since childhood. Forssman³ notes that female carriers of vasopressin-sensitive diabetes insipidus frequently become polyuric and polydipsic during pregnancy, while these manifestations are rarely observed in females transmitting renal diabetes insipidus.

In this pedigree the disease is transmitted through the heterozygous female carrier as a dominant sex-linked characteristic. The family history can be traced as far back as the Samoan maternal grandmother of Case 1. Case 1's mother, now 41, is the asymptomatic carrier of this disease; she has transmitted the disease to Case 1, a 17-year-old son, and to a 15-year-old daughter (both of whom live in Samoa). The firstborn child of Case 1, age 4 years, 6 months, whose father is Samoan, but not the father of the two youngest sons, is not affected.

DeWardener⁴ states that a decrease in the maximum urine concentrating ability may occur after the following conditions: (1) azotemia, (2) hypokalemia, (3) hypercalcemia, (4) head injury, (5) viral or spirochetal infections of the central nervous system, (6) obstructive uropathy, (7) renal tubular acidosis, and (8) aminoacidosis. All the laboratory studies and the family medical history eliminate the above possibilities in our patients. Darmady *et al*⁵ report three cases with nephrogenic diabetes insipidus who have shortened (one-half normal length) proximal convoluted tubules, and postulate that the shortness of the tubules may prevent reabsorption of enough water to prevent the distal convoluted tubules from becoming overburdened with hypotonic filtrate.

West *et al*⁶ note growth retardation, mental deficiency, and an increased mortality rate in two boys with nephrogenic diabetes insipidus; Kirman *et al*⁷ emphasize the close correlation between mental state and adequacy of fluid supply. The cases in our study have been treated with a low salt, low protein diet and adequate fluids, which is designed to decrease the obligatory water loss by reducing the solute load on the kidney.

SUMMARY

Four patients with vasopressin-resistant diabetes insipidus illustrate a familial sex-linked disease, transmitted by a heterozygous female carrier who may have variable expressibility of the clinical entity. Three patients with polydipsia, polyuria, and low urine osmolalities have been found to be resistant to vasopressin. A 23-year-old pregnant Samoan-Caucasian mother and her two sons have been studied, and the disease can be traced to a Samoan pedigree. This is the first case report of a Samoan pedigree with this disease, and also the first recorded study of familial vasopressin-resistant diabetes insipidus in Hawaii.

It is important to detect the female carrier because this disease causes severe polyuria and polydipsia and mental retardation, if an adequate fluid supply is not available, in the affected male offspring. There is a need for early diagnosis and prevention of mental retardation in children with this disease, especially since there is a normal life expectancy associated with vasopressin-resistant diabetes insipidus.

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REFERENCES

1. Hickey, R. C., and Hare, K.: The renal excretion of chloride and water in diabetes insipidus, *J. Clin. Invest.* 23:768 (Sept.) 1944.
2. Orloff, J., and Walser, M.: Water and solute excretion in pitressin-resistant diabetes insipidus, *Clin. Res. Proc.*, 4:136 (April) 1956.
3. Forssman, H.: On hereditary diabetes insipidus, with special regard to a sex-linked form, *Acta Med. Scand. Suppl.* 159, 1945, pp. 1-96.
4. DeWardener, H. E.: Polyuria, *J. Chronic Dis.* 11:199-211 (April) 1960.
5. Darmady, E. M., *et al*: The proximal convoluted tubule in the renal handling of water, *Lancet* 2:1254-7 (Dec.) 1964.
6. West, J. R., and Kramer, J. C.: Nephrogenic diabetes insipidus, *Pediatrics* 15:424 (April) 1955.
7. Kirman, B. M., *et al*: Familial pitressin-resistant diabetes insipidus with mental defect, *Arch. Dis. Child.* 31:59 (Feb.) 1956. ■

*Here are sodium and potassium values
in several characteristic foods eaten in Hawaii.*

Sodium and Potassium in Some Hawaii Foods

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• *The sodium and potassium content of some commonly used Hawaii foods were determined by flame photometry. Diets restricted in these electrolytes are used frequently for dietary management in clinical situations. A sample one-day diet restricted to 500 mg sodium and 1,000 mg potassium is given to illustrate the use of the data.*

SODIUM-RESTRICTED diets are used frequently for dietary management of hypertension and in situations in which retention of sodium in the body causes accumulation of fluid, e.g., in congestive heart failure, some renal and hepatic diseases, preeclampsia, or during prolonged administration of corticosteroids. Potassium-restricted diets are indicated in conditions asso-

ciated with disturbances of kidney function, e.g., chronic glomerulonephritis and acute renal failure. In recent years, patients with chronic renal failure have been maintained for extended periods by dialysis using the artificial kidney. Potassium deficiency may occur with limited or intravenous feeding following surgery, with prolonged cortical hormone treatment, with diuretic therapy and in other clinical situations. Dietitians require reliable estimates of the sodium and potassium content of foods to devise varied and nutritionally adequate diets with foods commonly used by the ethnic groups represented in Hawaii.

This work was undertaken at the request of the Hawaii Dietetic Association for its members and is presented at this time with the thought that it will be useful to physicians in Hawaii as well.

METHODS AND MATERIALS

Food items were selected and supplied by members of the Hawaii Dietetic Association.

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TABLE 1.—Sodium and Potassium in Hawaii Foods.
Household Units and 100-gram Portions.

FOOD ITEM ¹	APPROXIMATE MEASURE	WEIGHT	MOISTURE	SODIUM	POTASSIUM
		grams	per cent	milligrams	milligrams
1. Aku or skipjack (<i>Katsuwonus pelamis</i>)	3½ oz. serving	100	69.84	25	407
2. Bouillon, Dr. Bonner's organic mineral	By weight	100	51.99	5,060	2,618
3. Burdock root or Gobo (<i>Arctium lappa</i>) sliced ²	1 cup sliced	100	91.86	75	49
4. Cabbage, green mustard (<i>Brassica juncea</i>)	By weight	100	92.57	32	300
	1 cup, 1" pieces	65		21	195
5. Guava nectar base, frozen concentrate (<i>Psidium guajava</i>), Hawaii's Own brand	By weight	100	51.48	2	130
	1 cup of 3:1 dilution	240		1	78
	King of the Islands brand				
	By weight	100	53.07	4	138
6. Kamaboko, ³ steamed fish cake	1 cup of 3:1 dilution	240		2	83
	By weight	100	70.70	1,060	128
	1 slice, ¼" thick	10		106	13
7. Lettuce, Manoa (<i>Lactuca sativa</i>)	By weight	100	96.68	14	248
	1 leaf, 4" x 5"	10		1	25
8. Lychee (<i>Litchi chinensis</i>)	By weight	100	78.86	1	195
	1 medium, 1⅜" x 1⅛"				
	AP ⁴ , peeled and pitted..	12		0	23
9. Long rice, mung bean starch, product of Hong Kong	By weight	100	12.19	4	7
	1 package, 2 oz.	56		2	4
10. Mahimahi, frozen product of Japan (<i>Coryphaena hippurus</i>)	3½ oz. serving	100	74.60	77	416
11. Mango (<i>Mangifera indica</i>)					
	Haden				
	By weight	100	81.90	2	159
	1 medium, 3⅝" x 3¼"				
	AP, ⁴ peeled and pitted..	228		5	363
	1 cup, ½" cubes	170		3	270
Pirie	By weight	100	78.20	4	180
	1 medium, 3⅛" x 3⅛"				
	AP, ⁴ peeled and pitted..	172		7	310
	1 cup, ½" cubes	160		6	288
12. Miso, fermented soybean and rice					
	American Hawaiian Soy Co.				
	⅓ cup	100	42.84	2,918	112
	American Hawaiian Soy Co.				
	⅓ cup	100	39.53	3,318	126
	American Hawaiian Soy Co.				
	⅓ cup	100	42.24	3,593	136
	average 3 samples				
	1 tablespoon	17		557	21
	Fujii				
	⅓ cup	100	26.66	4,885	98
	1 tablespoon	17		830	17
	Fujii Junichi Shoten, product of Japan				
	⅓ cup	100	40.31	3,882	122
	1 tablespoon	17		660	21
Hawaiian Miso and Soy Co.	⅓ cup	100	22.32	3,783	188
	1 tablespoon	17		643	32
Aka Miso	⅓ cup	100	48.34	5,150	185
	1 tablespoon	17		875	31
13. Mountain apple (<i>Eugenia malaccensis</i>)	By weight	100	90.85	17	61
	1 medium, 2" x 1⅞"				
	AP, ⁴ pitted	56		10	34
14. Mushroom, dried, shiitake (<i>Lentinus edodes</i>)	By weight	100	7.38	25	1,600
	1 medium, 2¼" x 2¾" ..	6		2	96

TABLE 1.—Continued
Sodium and Potassium in Hawaii Foods. Household Units and 100-gram Portions.

15. Papaya, Solo, Waimanalo grown (<i>Carica papaya</i>)	By weight	100	84.63	4	175
	½ medium, 5" x 4" AP, ⁴ skin and seeds removed.....	144		6	252
16. Poi, paiai (<i>Colocasia esculenta</i>)	By weight	100	71.64	11	179
	1 cup	245		27	439
17. Saimin, undried ⁵	By weight	100	27.41	740	510
	1 cup	90		666	459
18. Seaweed Ogo (<i>Gracilaria coronofolia</i>)	By weight	100	90.94	245	2,220
	1 cup	80		196	1,776
19. Sushi nori (<i>Porphyra tenera</i>) E brand	By weight	100	9.37	457	4,986
	1 sheet	2		9	100
Hula brand	By weight	100	7.30	141	2,464
	1 sheet	2		3	49
20. Shoyu, soy sauce Aloha brand	½ cup	100	75.66	5,689	17
	1 tablespoon	16		910	3
Diamond brand	½ cup	100	71.14	5,613	376
	1 tablespoon	16		898	60
King brand	½ cup	100	77.11	5,376	40
King brand	½ cup	100	74.74	5,722	33
average 2 samples	1 tablespoon	16		888	6
Mitsuba brand	½ cup	100	71.52	6,168	257
	1 tablespoon	16		987	41
21. Taro (<i>Colocasia esculenta</i>) Hawaiian, leaves	By weight	100	81.52	3	684
	1 cup, 1" pieces	45		1	308
22. Japanese, corms or dasheen	1 medium, 3" x 1¾"	100	86.78	1	555
23. Tofu, soybean curd	By weight	100	88.95	17	84
	1 block	500		85	420

¹ All items in fresh, raw state except processed foods as indicated.
² Packed in water, sodium bisulfite added as preservative.
³ Salt, monosodium glutamate added.
⁴ AP—as purchased.
⁵ Salt, potassium carbonate added.

Duplicate 5- to 50-gram samples were ashed in a muffle furnace at 500°C. and dissolved in boiling hydrochloric acid and water. Aliquots were diluted to bring the sodium and potassium concentration within the appropriate range for analysis by flame photometry.

For moisture determinations duplicate 4- to 6-gram comminuted samples were dried at 70°C. for 48 hours, then held *in vacuo* over silica gel for another 24 hours. Loss in weight was reported as moisture content.

RESULTS AND DISCUSSION

Moisture, sodium, and potassium content of the foods are shown in Table 1 expressed both in 100-gram portions and in commonly used household measures. As expected, the sodium content of most fresh fruits and vegetables was low, whereas the processed soy products to which salt is added were extremely high in sodium. Miso of varying degrees of saltiness is a traditional product of Japan, shiro, or white miso, containing less salt

than the aka, or red miso. Shoyu produced in Hawaii contains 14 to 16 gm sodium chloride per 100 gm as compared to 18 gm in shoyu manufactured in Japan.¹

The potassium content in commonly consumed portions was generally high, as expected; potassium is widely distributed in foods, being especially rich in meats, dark-green leafy vegetables, whole-grain breads and cereals, and in fruits. Of the foods analyzed, long rice, burdock root, mountain apple, and the two chemically processed brands of shoyu had potassium values less than 100 mg per 100 gm. The richest sources appeared to be seaweeds and dried mushrooms, but generally these are not consumed in large quantities. The potassium requirement of man is unknown but an intake of 0.8 to 1.3 gm per day has been estimated to be the minimal need.² Fish, taro leaves and corms, and saimin appear to provide moderate amounts of potassium per serving.

Results of this study are of the same order of magnitude as that reported by others.^{1, 3}

TABLE 2.—*Diet for Kidney Dialysis Patient.*
500 milligrams sodium, 1,000 milligrams potassium, 40 grams protein, 1,800 calories.

SAMPLE MENU	APPROXIMATE MEASURE	ENERGY calories	PROTEIN grams	SODIUM milligrams	POTASSIUM milligrams
Breakfast					
Canned peaches	1 half medium	45	0.2	1	75
Farina, enriched, instant cooking	½ cup cooked	69	2.2	1	16
Sugar	2 tablespoons	92	0	0	1
Whole milk (Note: sugar and milk used in cereal)	½ cup	80	4.3	61	176
Soft-cooked egg	1 medium	78	6.2	59	62
Low sodium white toast	1 slice	64	1.9	7	44
Jelly	1 tablespoon	55	0	3	15
Unsalted butter	1 tablespoon	100	0.1	1	1
Snack					
Cranberry juice cocktail	½ cup	81	0.1	1	13
Hard candy	4 pieces	78	0	6	1
Lunch					
Mahimahi, broiled	1 ounce	24	5.2	27	116
Rice	¼ cup cooked	65	1.2	1	17
Bean sprouts	¼ cup cooked	8	0.9	1	44
Unsalted butter	2 tablespoons	200	0.2	3	3
Mango	⅓ cup ½" cubes	32	0.2	1	91
Snack					
Guava juice, frozen	½ cup	80	0.1	1	40
Marshmallow	3 pieces	75	0.6	10	2
Dinner					
Rib roast beef	1 ounce	68	7.9	16	104
Rice	¼ cup cooked	65	1.2	1	17
Canned peas	¼ cup	32	1.8	94	38
Low sodium white bread	1 slice	64	1.9	7	44
Unsalted butter	2 tablespoons	200	0.2	3	3
Manoa lettuce	1 leaf	1	0.1	1	25
Mayonnaise	1 teaspoon	36	0.1	30	2
Tea	½ cup	1	0	*	*
Snack					
Canned pear	1 half medium	44	0.1	1	49
Hard candy	4 pieces	78	0	6	1
Total		1,815	36.7	343	1,000

* Potassium and sodium studies have not been done on tea.

In Table 2 a sample one-day diet restricted to 500 mg sodium, 1,000 mg potassium, 40 gm protein, and 1,800 calories, for a young patient maintained by dialysis using the artificial kidney in a Honolulu hospital, illustrates the use of sodium and potassium values in Hawaii foods for estimating total daily intakes of these nutrients.^{3, 4, 5}

SUMMARY

The sodium and potassium contents of 23 foods commonly used in Hawaii were determined by flame photometry. The values are of the same order of magnitude as published values. Most fruits and vegetables contain low amounts of sodium whereas processed foods such as miso and shoyu contain extremely high amounts. The potassium content is generally high, particularly in seaweeds, fish, dried mushrooms, and taro leaves and

corns. A sample one-day diet restricted to 500 mg sodium and 1,000 mg potassium, used in a Honolulu hospital, is given to illustrate the use of sodium and potassium values of Hawaii foods for dietary management in kidney failure.

ACKNOWLEDGMENTS

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REFERENCES

1. Japan Nutritionist Association. Standard Tables of Food Composition. 3rd rev. ed. 130 pp., Tokyo, Japan, 1964.
2. National Academy of Sciences—National Research Council. 1964. Recommended Dietary Allowances. 6th rev. ed. Washington, D. C. Publ. 1146. vii + 59 pp.
3. Watt, B. K., and Merrill, A. L.: Composition of Foods. U.S. Dept. Agr. Handbk. 8. 190 pp. 1963.
4. St. Francis Hospital, Honolulu, Hawaii. Dietary Department. Personal communication.
5. Church, C. F., and Church, H. N.: Food Values of Portions Commonly Used—Bowes and Church. 9th rev. ed. J. B. Lippincott Co. Philadelphia and Montreal. 130 pp., 1963.

*Nucleoproteins in gastric cancer are different, and
11 of 21 patients developed antibodies against them.*

Immunological Studies of Cancer of the Stomach in Japanese

I. Immunochemical characterization of nucleoproteins of stomach cancer

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● *The present study was conducted to distinguish nuclear materials, isolated from human gastric tissues with and without cancer, by means of immunologic methods. Deoxyribonucleoproteins isolated with a solvent of low ionic strength, 0.7mM phosphate buffer, showed antigenicity in rabbits. Nucleoproteins from cancer tissue demonstrated additional antigenic properties, not found in normal tissues, with the aid of anti-cancer nucleoprotein serum. Conversely, cancer nucleoproteins lacked an antigenic component present in normal gastric tissues as demonstrated with anti-noncancer nucleoprotein serum.*

Treatment of the nucleoproteins by heating at 56°C. for 30 minutes, and with protease and DNase at 27°C. for 48 hours, abolished the above reactions.

Further experiments demonstrated that 11 (52.3%) sera from 21 patients with gastric cancer contained an antibody to nucleoprotein isolated only from cancerous gastric tissues. Two additional patients' sera gave positive precipitin reactions with normal as well as with cancerous nucleoproteins. The two sera which demonstrated positive reactions only with cancerous nucleoproteins also produced precipitins with 16 sera out of 45 patients, and four sera out of 24 patients, respectively. The results indicated the possible existence of nucleoprotein in cancer patients' sera.

THE POSSIBLE occurrence of a tumor-specific antigen which may be primarily or secondarily involved in the process of transformation of normal tissue to the neoplastic state has been considered in this study. The presence of a specific antigen in tumors and its corresponding antibodies has been demonstrated in animals by the experimental induction of neoplasms.^{1, 5, 12, 13}

A possible tumor-specific antigen has been demonstrated in human tumor tissue and in the serum of patients.^{3, 4, 9, 26} Moreover, the possible

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specific antibody to tumor antigen has also been found in human serum¹⁶ similar to that demonstrated in experimental animals.⁸

The present study was undertaken to discover the antigenic differences in the nuclear material, deoxyribonucleoprotein, which was isolated from gastric tissues with, and without, neoplasm. Immunochemical analysis of the nucleoprotein was carried out with the use of the specific antibody which was produced by the immunization of rabbits with the material.

The results obtained from the present study show that nucleoprotein from cancerous gastric tissue contains distinct antigenic components which are lacking in normal gastric tissue. Conversely, the cancer tissue lacked an antigenic substance which is possessed by normal gastric tissue.

MATERIALS AND METHODS

Serum samples were obtained from patients having cancer of the stomach whose diagnosis was established by x-ray examination, gastrocamera, and other suitable methods, and from patients who had had cancer removed by gastrectomy. A total of 58 samples from Japanese patients were supplied from various university hospitals and cancer centers in Japan and from Kuakini Hospital in Honolulu. The control sera were obtained from healthy Japanese men between the ages of 45 and 65.

Stomach tissues, with cancer (ten cases) and without cancer (six cases), were obtained from Japanese patients at Kuakini Hospital. Non-cancerous normal tissues were obtained from a similar area of patients with noncancerous diseases such as duodenal or gastric ulcers. The tissues were processed for the isolation of nucleoproteins immediately or within three days after storage at -20°C .

Water-soluble nuclear extracts were isolated from the tissues by a modification of the method described by Atchley and Bhagavan² in the following fashion. The tissues were washed with a 0.05M solution of sodium citrate $\cdot 2\text{H}_2\text{O}$, 0.15M NaCl, and 0.001M EDTA, and then the muscle layer and blood vessels were removed. The sliced epithelial layer was cut into smaller pieces and homogenized in a Potter-Elvehjem homogenizer, after which they were centrifuged at 600 g for ten minutes at 4°C . The supernatant material was removed and the nuclear sediment was washed twice with the above-mentioned solution by centrifugation. Subsequently, the sediment was again washed with a 0.7mM sodium phosphate buffer, pH 7.2, and then ten volumes of the buffer solution were added to the sedimented material, which was stored overnight at 5°C . The suspension was then centrifuged

at 4,600 g for 30 minutes at 4°C ., and the supernatant used for further experimental studies as a nucleoprotein material. Ultraviolet absorption of the nucleoprotein solutions was measured in a Beckman DU spectrophotometer.

The chemical properties of the isolated nucleoprotein preparations were analyzed by the following methods. The protein content was determined by the biuret method.¹⁰ DNA was determined by the diphenylamine reaction.⁶ RNA was separated by the method of Ogur and Rosen¹⁷ and measured by the orcinol method.⁶ Aminosugars like glucosamine-HCl were determined by the method described by Levvy and McAllan,¹⁴ neutral sugars were measured by the method described by Dubois *et al*⁷ and the N-acetylneuraminic acid content was measured by the method described by Warren.²⁴

Antisera against nucleoproteins were prepared by immunizing the materials with an equal volume of Freund's complete adjuvant. Nucleoproteins obtained from cancerous and normal tissues were combined in two respective pools and the protein concentration was carefully adjusted to 10 mg% before analyses and immunization procedures.

New Zealand albino rabbits weighing approximately 3.0 kg were immunized with the materials. Eight rabbits were injected in both hind foot pads with 0.5 ml of a mixture of nucleoprotein with Freund's adjuvant. Four rabbits were injected with cancerous materials and the other four with material from normal stomach tissue. Three weeks after the initial injection, 0.5 ml of each material without Freund's adjuvant was injected twice a week for two weeks into the ear veins. Ten days after the last injection, the rabbits were bled by heart puncture.

Immunoanalyses for the reaction of the immune sera and the original nucleoprotein material were carried out by Ouchterlony's double diffusion method¹⁸ and immunoelectrophoresis²¹ in agar gel. One-half per cent Ionagar* was dissolved in a 0.7 mM sodium phosphate buffer for both immunodiffusion methods and the immune sera were dialyzed against the same buffer before use. The capacity of the wells was 0.05 ml for the double diffusion and immunoelectrophoretic analyses.

The nucleoproteins were treated with protease,[†] DNase,[‡] and RNase,[§] which were added to the nucleoprotein solution to approximately a 1% concentration, and the pH was adjusted to 7.0. Treatment was carried out at 37°C . for 24 and 48 hours, and then 0.001M EDTA solution was

* Ionagar, "Oxoid" Division of Oxo Limited, London.

† Protease, Pacific Biochemical, Inc., Honolulu, Hawaii.

‡ DNase (Lot No. 37B-2740), Sigma Chemical Company, St. Louis, Missouri.

§ RNase (Lot No. 65B-8590), Sigma Chemical Company, St. Louis, Missouri.

TABLE 1.—Chemical analysis of nucleoprotein extracts.

CONTENT	CANCEROUS MATERIAL mg/ml	NONCANCEROUS MATERIAL mg/ml
Protein.....	0.350 – 1.178	0.356 – 0.668
DNA.....	0.12 – 0.41	0.20 – 0.48
RNA.....	0.010 – 0.035	0.018 – 0.050
Amino sugars.....	0.045 – 0.052	0.013 – 0.039
Neutral sugars.....	0.092 – 0.121	0.081 – 0.126
N-acetylneuraminic acid.....	0.029 – 0.048	0.040 – 0.044

added to make 1% in the mixture. Heating tests were carried out against nucleoprotein at 56°C. for 30 minutes.

The complement fixation tests were carried out by the method of Kabat and Mayer.¹¹

RESULTS

An ultraviolet absorption spectrum of the nuclear extracts showed a minimum at 240 mm (millimicrons) and a maximum at 260 nm (Fig. 1).

The chemical properties of the isolated nucleoproteins are shown in Table 1. The results demonstrated that there are slight, if any, differences in the gross chemical constitution of the cancerous and noncancerous materials.

Figure 2 shows the results of Ouchterlony double diffusion tests between antisera and nucleoproteins. Nucleoprotein from normal tissues formed three precipitin lines with the antiserum against the original material while two lines, one being a faint reaction, were observed with anti-serum against the nucleoprotein of cancer tissue. Two lines from each of both reactions were identical. Nucleoprotein from cancerous tissues

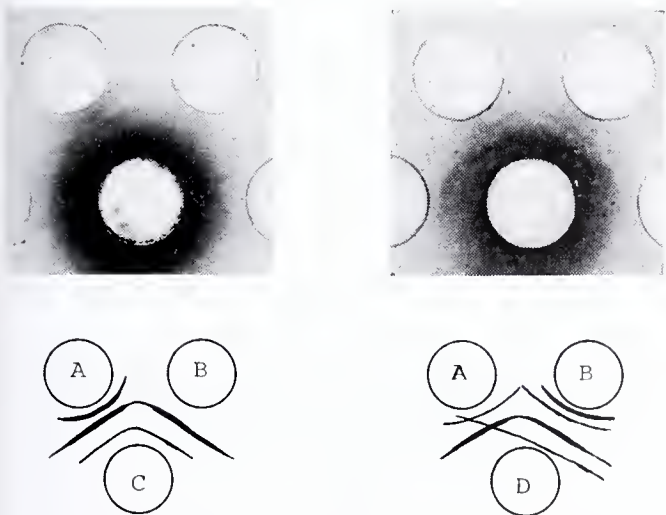


FIG. 2.—Results of Ouchterlony diffusion tests between antisera and nucleoproteins. Wells are indicated as follows: (A) Noncancer nucleoprotein, (B) Cancer nucleoprotein, (C) Anti-noncancer nucleoprotein serum, (D) Anticancer nucleoprotein serum.

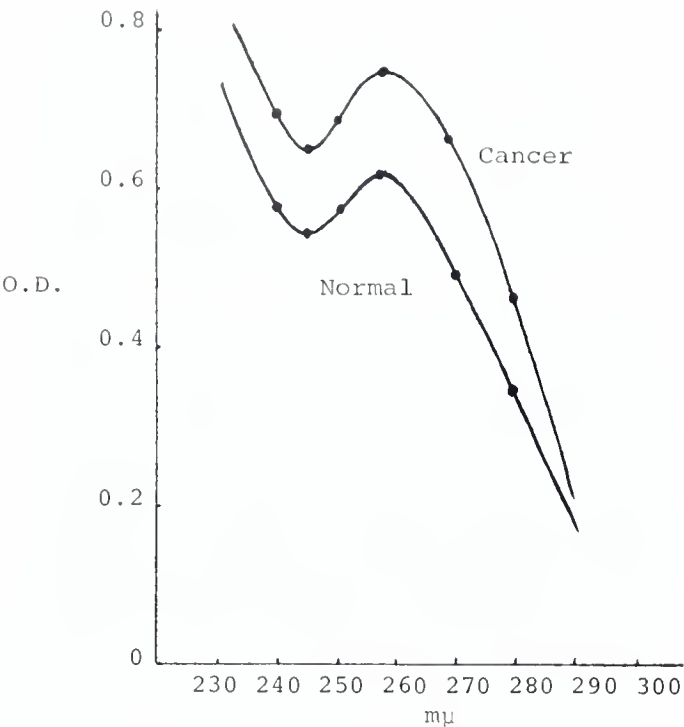


FIG. 1.—Spectrophotometric absorption curve of nucleoproteins.

formed two precipitin lines with anti-noncancer nucleoprotein serum while four lines, one being a faint reaction, were observed with anticancer nucleoprotein. Two lines from each reaction were identical. Within each group of rabbits, each anti-serum against the different sources of nucleoprotein produced similar reactions with the original material.

In the immunoelectrophoretic analysis of the above diffusion experiments (Fig. 3), the anti-noncancer nucleoprotein serum demonstrated two precipitin lines with the initial material. A faint precipitin line was formed near the origin and extended toward the cathode with the other line

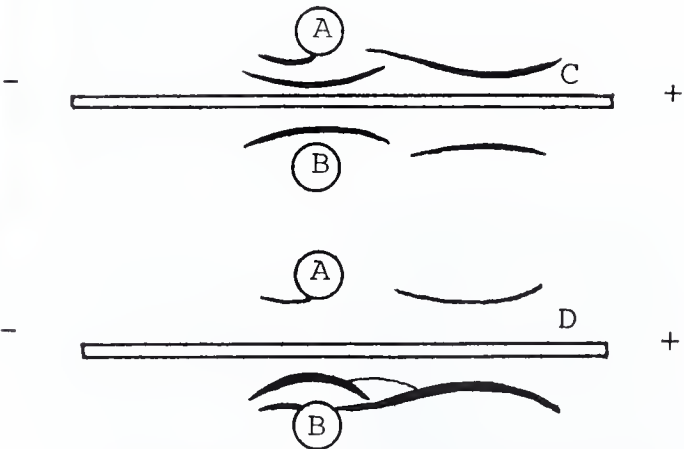


FIG. 3.—Immunoelectrophoretic patterns of the reaction between antisera and nucleoproteins. Wells are indicated as follows: (A) Noncancer nucleoprotein, (B) Cancer nucleoprotein, (C) Anti-noncancer nucleoprotein serum, (D) Anticancer nucleoprotein serum.

TABLE 2.—Results obtained in the complement fixation test.

DILUTION OF ANTIGEN	DILUTION OF ANTISERUM							ANTIGEN CONTROL
	1:2	1:4	1:8	1:16	1:32	1:64	1:128	
Original (1.0 mg/ml)	4+	4+	4+	4+	4+	4+	4+	4+
1:2	4+	4+	4+	4+	4+	4+	4+	4+
1:4	4+	4+	4+	3+	2+	2+	2+	0
1:8	4+	4+	3+	2+	2+	1+	1+	0
1:16	4+	3+	2+	2+	1+	1+	W	0
1:32	4+	3+	2+	1+	1+	W	0	0
1:64	3+	2+	2+	1+	W	0	0	0
1:128	3+	2+	2+	1+	0	0	0	0
Immune serum control	4+	2+	1+	0	0	0	0	0

The percentage of hemolysis was converted to + notation so that 0 to 5% is 4+, 10 to 35% is 3+, 40 to 60% is 1+, 90 to 95% is w, and 95 to 100% is 0.

located in the far anode area where the albumin migrated when normal human serum was applied in immunoelectrophoresis. The tail of this latter line extended into the α_2 region. However, two of these lines were not detected when noncancer material was used.

These reactions were eliminated by heating the nucleoprotein at 56°C. for 30 minutes, and also disappeared after treatment with protease and DNase for 48 hours. However, treatment with RNase did not abolish the reactions.

Antisera produced positive complement fixation tests with both nucleoproteins, and normal rabbit sera failed to demonstrate the reaction. Anticomplementary effects were observed with nucleoprotein concentrations greater than 0.25 mg/ml and with the immune sera up to a dilution of 1:8. Table 2 shows the reaction of complement fixation tests between cancer nucleoprotein and antiserum against the antigen. Antiserum to noncancer nucleoprotein showed a similar pattern with noncancer nucleoprotein.

A precipitating reaction was also observed when the sera from a total tested 21 patients with cancer were placed against cancer and noncancer nucleoproteins in Ouchterlony agar plates (Fig. 4). The percentage of positive reactions found was 61.8 per cent (13/21); 52.3 per cent (11/21) showed positive reactions only with cancer nucleoprotein

and two cases showed positive reactions with both cancer and noncancer nucleoproteins. One of the remaining eight cases showed a positive reaction with noncancer nucleoprotein. Some of the normal serum showed a precipitin reaction with cancer nucleoprotein but not with noncancer nucleoprotein. The precipitin line of the reaction between anticancer nucleoprotein serum and cancer nucleoprotein showed a partial identity with the line which was formed by the reaction between cancer nucleoprotein and cancer patient's serum.

The sera of the cancer patients which demonstrated a positive precipitin reaction with cancer nucleoprotein also showed a reaction with other cancer patients' sera (Fig. 5). A checkboard analysis showed that 16 of 45 cancer patients tested demonstrated a positive precipitin reaction with the serum (No. 17) which showed a positive precipitin reaction with cancer nucleoprotein. With another serum (No. 18) which also reacted with cancer nucleoprotein, four out of 24 cancer patients tested demonstrated a positive precipitin reaction. The reaction was not demonstrated with serum from patients who had cancerous gastrectomies more than three weeks prior to analysis, or with normal human serum.

Immunoelectrophoretic analysis of the above reaction showed one precipitin line. This line was identical to one of the lines formed by the reaction between anticancer nucleoprotein and cancer nucleoprotein and was located in the albumin region during immunoelectrophoresis.

These positive results of serum and serum reactions in immunodiffusion tests were also demonstrated by complement fixation tests.

DISCUSSION

The present study indicated that water-soluble nucleoprotein, extracted from human gastric tissue with cancer, contains some additional antigenic

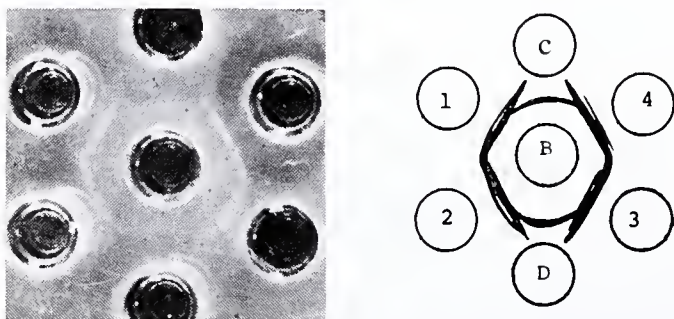


FIG. 4.—The precipitin reactions of cancer nucleoprotein (B) and cancer sera (1 to 4). C and D indicate anticancer nucleoprotein serum and anti-nonnucleoprotein serum.

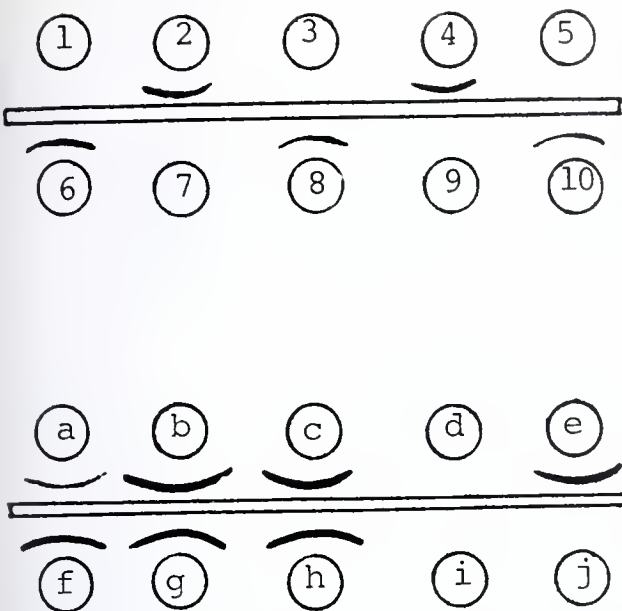


FIG. 5.—The precipitin reactions of the cancer patient's serum (No. 17) and serum from cancer patients and normal individuals. The numbers indicate cancer patient serum (2, 4, 6, 8 and 10) and normal serum (1, 3, 5, 7 and 9) in the upper pattern. The letters in the lower pattern indicate all cancer patient sera.

components when compared with normal gastric tissue. Therefore, it is possible that the extract from human cancer tissue possesses cancer-specific antigens. Both DNA and protein were required for the demonstration of immunological activity, since treatment of the materials with either protease or DNase abolished the reactivity. However, nucleoprotein from cancerous tissues was also found to lack a component which normal gastric tissue possesses, when anti-noncancer nucleoprotein serum was used against both cancer and noncancer nucleoprotein materials. Thus, it is possible that antigenic substances may be both deleted and gained in gastric cancer tissue.

Perez-Cuadrado, Haberman, and Race¹⁹ used DNA-bound protein isolated from adenocarcinoma of the colon and demonstrated that their material could induce the formation of cancer-specific antibodies in animals. In addition, they found that the pattern of the reactions of these antibodies against various cancers seemed to be dependent upon the source of the cancerous DNA-bound proteins.

It is well known that the serum of lupus erythematosus (LE) contains an antibody against DNA-protein, and the results have been explained on the basis of an autoimmune phenomenon.^{20, 23} The high frequency of antibody against DNA-protein complexes in the sera of patients with cancer in this study indicates some similarity between the LE phenomenon and the present results. The results might represent a primary

autoimmune mechanism in cancer production or a secondary consequence of cancerous alteration of gastric tissue. However, a recent study²⁶ suggests that the antibody demonstrated in cancer serum which reacted with DNA-bound proteins of gastric cancer tissue differs from the antibody associated with the LE system.

The positive precipitin reactions found in the cancer sera of the present study indicated the presence of an antigen as well as an antibody. The lack of either or both reactants in other cancer patients' sera may be related to the different stages of gastric cancer, or treatment with antimetabolites or gastrectomy.

It may be assumed that the temporal immunological sequences are associated with the introduction of either exogenous or endogenous antigens.

ACKNOWLEDGMENTS

The authors are deeply indebted to Drs. K. Akazaki and K. Kobayashi, Aichi Cancer Center, Japan; K. Inoguchi, Kyushu University, Japan; D. Jinnai, Osaka University, Japan; and G. N. Stemmermann, Kuakini Hospital, Honolulu, Hawaii, for supplying serum samples from cancer patients and gastric tissues to make this study possible.

The authors wish to acknowledge Dr. R. O. Brady, Chief, Laboratory of Neurochemistry, National Institutes of Health, Bethesda, Maryland, for his critical review of this paper and his valuable discussion, and also Dr. Richard K. Blaisdell, Professor and Chairman, Department of Medicine, University of Hawaii School of Medicine, for his critical review.

References will appear in reprints of this article.



The President's Page



At the annual Christmas party of the Hawaii County Medical Society one of my fellow doctors asked me, "Bob, how come there is so much discrimination against professions? Why is the IRS making it so difficult for physicians to incorporate?"

Come to think of it, it was a pretty good question. I could not answer him, but he did set me thinking about this problem. I asked my attorney why it was so difficult for the medical profession to incorporate. He said something to the effect that medical care was such a personal thing that it was next to impossible for such a personal service to be rendered effectively by an impersonal thing like a corporation.

Of course, all is not lost, and it is indeed fortunate that some groups have been willing to become test cases. In a string of four cases this year and last, the U. S. District Courts have ruled invalid the regulations restricting professional groups from obtaining corporate tax status. Because of this action, a number of professionals are taking a second look at the idea of incorporating.

Of course, there are a number of cautions. First and foremost is the fact that the IRS has not changed its regulations and, in fact, is appealing at least three of these cases.

Secondly, a corporation is not the answer for every professional man and every professional group. Some of us are not suited temperamentally to accept restrictions on our independence. Such restrictions are inevitable in a corporation.

Others would not receive sufficient financial benefit. The higher a man's tax bracket, the more he stands to gain from incorporation. It has been said that it would be inadvisable for anyone making less than \$25,000 a year to incorporate.

One benefit we are deprived of is the right to establish professional profit-sharing plans, contributions to which are tax-deductible as business expenses, and income from which is not taxed until retirement, and then as long-term capital gains.

We also lose out on group life insurance, tax-free up to \$50,000 of coverage, and on \$100 weekly tax-free sick-pay plans. The tax breaks available to corporate executives are still very much greater than those available to us under the Keogh Plan (H R 10).

Fortunately, we have a group who are willing to tackle the IRS. It may be that doctors will be allowed to incorporate, and if such happens, we will certainly suggest that physicians get together with their accountants and financial advisors and an attorney who is competent in this area and discuss this in detail.

Good luck to you all!

Robert W. Meyerowitz

The Gastric Ulcer Problem

The question of the proper treatment for ulcerating lesions of the stomach has been vigorously argued over the years, with neither the conservative internist camp nor the radical surgical proponents yielding in their dogmatic declaration of which is the right or the best method.

The proper selection of a patient for operative treatment and the selection of the proper operation should involve little concern with the possibility of cancer. In the light of published statistics, more recent understanding of gastric physiology, and the clarification of the pathology, it is now possible to formulate standards of therapy which should be acceptable to even the extremists of the two schools.

- The pyloric channel ulcer and the distal pyloric ulcer, even though eroding through and surrounded by gastric mucosa, have the same clinical symptoms and the same pathophysiology as the duodenal or so-called peptic ulcer; each

should be considered to *be* a duodenal ulcer; each should be treated in the same identical way as a duodenal ulcer; and the indications for surgery are the same.

- Erosive gastritis is generally secondary to ingestion of anti-inflammatory agents, and becomes a surgical problem only when life-threatening hemorrhage cannot be otherwise controlled.

- Gastric ulcer resulting from the impaired physiology secondary to duodenal ulcer requires surgery for cure, and the procedure should be that indicated for duodenal ulcer: hemigastrectomy and vagotomy.

- The deep, penetrating, chronic gastric ulcer is a recurring disease. While the ulcer may be healed by nonsurgical means, the diathesis rarely is cured. The hazards associated with the recurrences far exceed the morbidity and mortality of antrectomy, and therapy other than surgical removal can only be based on a poor understanding of what can be expected from other forms of treatment.

JAMES W. CHERRY, M.D.

Birth Defects Center

Any child up to the age of 19 with a suspected birth defect is eligible for evaluation and care at the newly established Birth Defects Center at Kaulaolani Children's Hospital.

A nominal registration fee is charged for the first visit, but there are no charges thereafter except for such out-of-pocket expenses as laboratory tests and x-rays, drugs, inpatient care, physical therapy, and so on. The Departments of Health or Social Services may be able to defray these if they are not otherwise covered, as by insurance. Basic financial support is from the National Foundation.

The Center is prepared to offer comprehensive diagnostic evaluation and advice, including evaluation of the home environment, and will either

manage the case and counsel the parents, or follow the case in cooperative conjunction with the family physician, whichever is desired.

The Director of the Center, Dr. Sharon J. Bintliff, and the Assistant Director, Dr. Walton K. T. Shim, are prepared to speak before professional or lay groups on the subject of birth defects. They also are prepared to make available the services of more than 400 specialists from the staff of the Children's Hospital and the faculty of the University of Hawaii Medical School.

New patients are accepted from 8:30 A.M. until noon on the second and fourth Mondays of each month, by appointment. The Center is open for business five days a week, from 8:00 A.M. to 4:30 P.M. The telephone number is 531-3511.

Report of the Health and Hospital Planning Council of Honolulu

The "Areawide Comprehensive Health Planning Agency for the Island of Oahu" recommends, in a report released on October 3, that it become the State regulatory agency—outside of government, but with legal authority—for comprehensive health planning in the State.

Omar Tunks, the Executive Director, takes responsibility for some statistics purporting to show lessening occupancy of hospital beds on Oahu. He cites a decline of 30 per cent in hospital admissions per capita of population during the past five years, and a 15 per cent increase of the hospital census during the same period, despite a population increase of 24 per cent during this time. He projects a population increase of about 24,000 per year during the next 17 years; yet we actually had a net increase of over 40,000 during 1967, and surely there is no reason to expect this increase to diminish in the future.

The report points out that suburban residents "fail to seek care in the hospital supporting their area," yet assigns the "highest priority" to development of a hospital in the Waipahu-Ewa-Waianae-Nanakuli area, in order to "relieve the pressure on metropolitan hospitals for medical-surgical care."

Physicians seem to be plentiful in Hawaii: their ratio to population rose from one for every 781 persons in 1965 to one for every 713 in 1967; as the report soberly adds, "consequently, there are substantially more physicians [270, or well over 50 per cent more!] practicing in Honolulu today than three years ago."

Nurses are plentiful too: 442 for each 100,000 population, or almost 50 per cent more than the "ample and desirable ratio" recommended (or at least tolerated!) by national authorities, according to the report.

The Council endorses and supports the expansion of the University of Hawaii Medical School into a four-year school "as soon as feasible . . . subject to demonstration of need through an in depth [*sic*] feasibility study," a sort of left-handed vote of confidence, which the University might well view with mixed feelings.

The Council expresses alarm over proposals

which they say would add over 1,000 acute care hospital beds in Honolulu within the next five years. They reiterate their position that "there is no demonstrated need for a new general acute care hospital in the Honolulu area for the next twenty years." What should be done, they say, is to "modernize and strengthen" [enlarge?] "existing hospital centers"; the proposed Straub and Nuuanu Valley Hospitals are not endorsed.

Yet the Council supports "the location of physician offices adjacent to hospitals"; it is acknowledged that this "would allow hospital centers to serve the community more efficiently." There is ample support for this view: for example, Rutstein, of Harvard, says that "The efficient application of automation and technology to medicine lends further weight to the arguments for a regionalized medical care system in which the physician has his office in a group practice unit immediately accessible to the facilities and equipment of the hospital centre." But the Council wants it applied, apparently, only to existing hospitals, not to existing groups.

As to statutory control, or "franchising," of health facility construction, the Council painfully and reluctantly rejects these "at this time" in favor of voluntary participation in planning. If statutory controls *are* instituted, however, they feel that *they* should be the agency to apply them. Fundamental to this question is the strong recommendation by Victor Fuchs, Wilbur Cohen, and others that "innovation and experimentation" are vital to a solution of the health manpower problem confronting the world and every community in it. Our own State Comprehensive Health Planning Advisory Council in its statement of policy includes this as one of its basic recommendations.

Simple defense of the status quo, and reliance on already established and "proven" techniques for rendering health care, will get us nowhere except where we already are; yet it is the safest course for such an advisory body to pursue, and such bodies almost always do pursue it, for that reason. We would advise the Health and Hospital Planning Council to take a new and closer look at its basic data, and another at its recommended solutions for our problems. ■



- Chest film taken on initial visit of a 33-year-old man who had a two-month history of hemoptysis, wheezing, shortness of breath, and a 20-pound weight loss. The patient had been a heavy smoker since the age of 13 years.
- Coronal tomograms of the right upper lung field demonstrating an apparently neoplastic mass in the proximal right main stem bronchus and encroaching on the tracheal bifurcation. An emergency bronchoscopy and right thoracotomy were performed six days later because of almost complete tracheal obstruction.

- What is your diagnosis?
- Answer is below.

A biopsy of the mass at the time of surgery showed anaplastic epidermoid carcinoma. The patient received 6,500R tumor dose to the hilum of the right lung and mediastinum. This was followed by re-expansion of the right lung and symptomatic relief. However, the patient expired six months later.

Submitted by the
RADIOLOGICAL SOCIETY OF HAWAII
D. R. GRININGER, M.D. ■



Hawaii Academy of General Practice

The Personal Physician

They speak of the general practitioner of medicine as a Dodo—a bird that was doomed to extinction.

But . . . so long as Mankind is in existence (and there are some who express doubts that it will long be, in this day and age of the fissionable atom!) when any one person is in need of help, he will seek out another person, not a group of people.

Our Federal government has expressed the wish—and HEW just loves to translate “intentions” into “commands”—that every citizen should have the “right” to the very best and the most modern medical care that the scientist-medicos of this country can offer, irrespective of creed, color, or condition of pocketbook. HEW translates this into the sort of care available from large clinics and groups—a full complement of specialists under one roof, preferably associated with a medical school or a research center, and preferably a closed panel system for reasons of economy.

This is the concept of Comprehensive Medical Care to which the Congress was led by misguided do-gooders.

It will never work!

First, the people themselves will not stand for being dragged in bodily off the streets to be subjected to questionnaires, automation, mass screening, and mechanical probing of their private orifices. It is too impersonal.

Secondly, it will be another demonstration of an oft-proven adage: Those who do not learn from history are sentenced to repeat its mistakes. A recent publication of the Hawaiian Historical Society includes an account by O. A. Bushnell, of our own medical school faculty, of the attempt by the Congress to establish a model hospital at Kalawao,

on Kalaupapa Peninsula, Molokai. The Hawaii Chapter, AAGP, was honored at its 1968 annual meeting by Dr. Bushnell, who related to us the essence of this story of frustration. From the great day of the opening ceremonies on, none of the patients of Kalaupapa volunteered to become the patients in this palatial structure dedicated to research. Why was this so? Because the personal touch was both literally and figuratively interdicted by regulation.

If the government is so determined that each and every American citizen never be denied the very best and the very latest in medicine, it should have first sought the advice of those of us who did and still do the practicing in the “grass roots” areas of medical care—the general practitioners in the out-of-the-way communities.

We would have advised: (1) That each personal physician be assisted in every possible way to have made available to him the services of specialists and top-notch facilities; (2) that each personal physician be assisted to continue his professional education, encouraged to do so at no loss to his pocketbook, and perhaps even pressured a bit; (3) that the people be educated towards seeking for themselves (without coercion, but with incentive toward preventive care) the remarkable health benefits available to them in this country; and (4) that the people who do not care to be sullied by the least hint of hypochondriasis be left free to enjoy their vices and their disabilities, and let the health statistics be damned!

We would have advised that the general practitioner be trained, and that he be certified when capable, to become the personal physician, whose individualized concern and empathy for his patients is worth more than a thousand pills or a million dollar piece of apparatus. ■

J. I. FREDERICK REPPUN, M.D.

Dangerous Animals Loose in Hawaii

In this modern age, which animal kills the most people each year? Not the savage lion or stealthy leopard . . . but, in all probability, the gentle domestic cow. The reason, of course, is the fat content and composition of modern cows' milk. Being high in saturated fats and low in polyunsaturates, this overly nutritious fluid may hasten the onset of atherosclerosis among those unfortunates addicted to its use.

Apparently this was not always so. The milk of yesteryear was lower in those dangerous saturated fats, due to the poor quality of grazing land and feedstuff. Nowadays the cattle eat better and their milk has become more atherosclerogenic. Perhaps those advertisements which entreat us to drink at least a pint of milk a day are potentially as dangerous as the heinous cigarette commercials!

As a serendipitous aside, nutritionists have been puzzled by certain African tribes that live almost exclusively on cattle and dairy products and yet have almost no atherosclerosis. Perhaps the answer to this enigma lies in the very poor quality of the grazing land resulting in milk which is low in saturated fats, and thus of only weak atherosclerogenic potential.

African Safari

Americans are indefatigable travelers and, assuming no prohibitive edicts from Washington, are expected to vacation abroad in even greater numbers during 1969. Searching for something new many will consider visiting Africa, particularly East Africa where large game reserves with abundant wild life are powerful attractions. These areas have particular medical problems and the physician should advise intending travelers of the best means of avoiding serious illness. The following advice from our tropical medicine consultant applies particularly to East Africa (Kenya, Tanzania, and Uganda).

The mandatory "shots" are yellow fever and smallpox, but additionally tetanus, typhoid, and oral polio boosters are strongly recommended. As no chloroquine-resistant strains of malaria have been found in the area, chloroquine antimalarial prophylaxis is suitable. Chloroquine 500 mgm is taken once weekly beginning two weeks prior to

entering and continuing for four weeks after leaving the malarial area.

Certain of the game reserves are infested with tsetse flies, some of which are infected with trypanosomiasis (sleeping sickness). A new drug, Pentamidine, has been suggested as a prophylactic against trypanosomiasis but its use is *not* recommended because (1) the drug is presently only available for investigational purposes and (2) its administration may mask the signs and symptoms of systemic trypanosomiasis while allowing a silent and undetected CNS infection. Presently, the best protective measure seems to be liberal spraying with insect repellent while in tsetse areas.

Each traveler should carry a small "medical kit" containing a ten-day supply of a broad-spectrum antibiotic such as ampicillin or tetracycline, Lomotil for gastrointestinal upsets and Halazone tablets for water purification.

Luau Feet

According to Dr. Bent Langfeld of Aarhus, Denmark, acromegaly may be diagnosed by measuring heel pad thickness on a lateral x-ray. He believes that an early sign of acromegaly is thickening of the skin and subcutaneous tissue over the extremities. In a series of 500 normal subjects the thickness of the heel pad ranged from 12 mm to 22 mm with a mean of 18. Acromegalics ranged from 22 mm to 45 mm with a mean of 28.4.

Comment—Caution must be exercised when applying these criteria to the Hawaiian population, among whom, in many cases, the use of footwear is neither a social or a climatic necessity.

Hazards of Abdominal Irradiation

A rather disturbing report from Winnipeg, Canada, concerns the effects of abdominal x-ray studies (upper GI, barium enema, cholecystogram, etc.) in women of childbearing age. Chromosomal aberrations occurred with a significantly higher frequency among the offspring of mothers exposed to relatively large doses of diagnostic x-rays, even among those born several years after the radiation exposure. Also noted was a slight decrease in the proportion of males born to irradiated mothers.

(Uchida, I. A., Maternal Radiation and Chromosomal Aberrations, *Lancet* [Nov. 16] 1986). ■

WILLIAM PHILIP JONES, M.D.

This is the seventy-sixth installment of In Memoriam—Doctors of Hawaii.

Edwin Dearborn Kilbourne, Sr.

Edwin Dearborn Kilbourne, Sr., was born June 6, 1877, in Elgin, Illinois, the son of Edwin A. and Louise (Kilbourne) Kilbourne. He attended



the schools of Elgin. Without any pre-medical work and on the basis of his grade in an examination, he was admitted directly into Northwestern Medical School from which he graduated in 1899.

On June 8, 1899, he married Miss Alberta I. Marshall in Chicago. Three children were born to the doctor and his wife: Janet Louise, Kathryn (Mrs. John Breeden), and Edwin Dearborn, Jr.

From 1899 to 1902 Dr. Kilbourne was bacteriologist for the Chicago Department of Health, and from 1901-1902 he was clinical instructor in pediatrics at Northwestern Medical School.

Entering the Army Medical Corps in 1902, Dr. Kilbourne made the Army his career for the next twelve years. During this period he attended the U.S. Army Medical School in 1903, and was a member of the Army Board for the Study of Tropical Disease in Manila 1909-1910. He became an authority on tropical and military medicine and wrote a number of papers on these subjects.

In 1914 Dr. Kilbourne resigned from the Army and opened an office for private practice in Honolulu. Although he was in general practice his chief interest was always surgery. He was on the staff at Queen's and Children's hospitals, was a member of the Territorial Board of Health, and in 1915 served on the Board of Medical Examiners.

Dr. Kilbourne left Honolulu in 1928 to practice in Los Angeles, where he was a member of the staff of the Good Samaritan Hospital and the Good Hope Clinic. The following year he

moved to Santa Ana to do the surgery for the Santa Ana Clinic and was on the staffs of the St. Joseph and Santa Ana Valley hospitals. In March, 1931, Dr. Kilbourne returned to Honolulu where he practiced until 1936 when he went back to California and opened an office at Los Gatos. At that time, there being no hospitals in Los Gatos, the doctor was on the staff at San Jose and O'Connor's hospitals in nearby San Jose and served as president of the staff at O'Connor's Hospital for one year.

On his retirement in January, 1945, he lived in Palo Alto for a time, then in Saratoga, and finally in Los Altos. Dr. Kilbourne died in Sunnyvale, California, on February 26, 1962, at the age of 84.

While in Honolulu the doctor was a member of the Hawaii Medical Society (president in 1916), University Club, Oahu Country Club, Hawaii Polo and Racing Club, and from 1914 to 1915 was a major in the Hawaii National Guard.

He also belonged to the American Medical Association, the American College of Surgeons, Association of Military Surgeons of the United States, American Academy of General Practice, Los Angeles Surgical Society, Santa Clara County Medical Society, Medical Society of California, and Nu Sigma Nu fraternity.

Carl Ramus

Carl Ramus, born in 1872, was a graduate of Rush Medical College, Chicago, class of 1897. On March 9, 1899, he joined the U.S. Public Health Service.

Dr. Ramus arrived in Honolulu aboard the S.S. "Mongolia," on August 4, 1904, and was assigned to the Quarantine Station to assist Dr. Leland Cofer. Three years later he was temporarily put in charge when Dr. Cofer was called away for what proved to be an absence of nearly nine months. On Dr. Cofer's return, Dr. Ramus was given a three-month leave, which he used to attend clinics both in New York and in Europe. At the end of his leave, the doctor was ordered to Ellis Island, and it was not until August, 1909, that he returned to Honolulu. This time he was first assistant to Dr. William Hobdy and had attained the rank of Passed Assistant Surgeon. Three months later Dr.

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University of Hawaii.....

November 1 through 4, 1968, **Windsor Cutting, M.D., Neal Gault, M.D., Robert Noyes, M.D.,** and **Mr. John McNeil**, Fiscal Officer for the School of Medicine, attended the annual meeting of the Association of American Medical Colleges at Houston, Texas. Medical schools were urged to actively revise the content and methods used in the total span of the education of the physician so that his professional competence will be most relevant to meeting the changing health needs of the people. Five points were stressed: (1) Medical schools must increase their output of physicians. All schools should immediately increase enrollment. [U.H. increased the number of entering students 20 per cent this year.] (2) Medical schools must admit more students from geographic areas, economic backgrounds, and ethnic groups now inadequately represented [U.H. has two medical students from Micronesia]. (3) Medical schools must individualize the education of the physician to fit the students' varying rates of achievement, various educational backgrounds, and differing career goals. [This fits a four-year curriculum better than the two-year curriculum we have at present at the U.H.]. (4) Medical school curricula should be developed by interdepartmental groups that include participation of students. Curricula should be ratified by the faculty as a body rather than by individual departments. [A retreat of the faculty of the U. H. School of Medicine will be held in July to implement this recommendation.] (5) The Medical School must now assume a responsibility for education and research in the organization and delivery of health services. [U.H. expects to participate actively in the HMA program on continuing medical education, and in conjunction with the Schools of Nursing, Public Health, and Social Work, help to set up a model of comprehensive health care in a poverty area.]

The Academic Development Plan II, since 1963 the guideline for the development of the College of Health Sciences and Social Welfare (as well as all other schools and colleges of the University), is currently in the final stage of revision. This document contains important modifications of the University's previous policy, particularly that related to public service. In addition to planning for an expansion of the Medical school class from 34 to 50 students, considering a program for edu-

cating health officers to serve areas in the Pacific where it is not yet feasible to supply physician services, and creation of programs in tropical diseases and physical and occupational therapy, Academic Development Plan II specifically provides for a study, to be made by a group of outside consultants, on the feasibility of developing a four-year School of Medicine. It is expected that legislation to this effect will be entered in the spring session of the State Legislature.

On October 30 **Professor Sir Charles Dodds** presented two lectures on birth control pills at the Sinelair Auditorium, Leahi Hospital. Also here from New York to attend the lectures were **Drs. Walter Modell** and **Frank Berger**. A memorable reception was held for Sir Charles at the home of **Don Marshall, M.D.**

Olaf Skinsnes, M.D., Professor of Pathology, was elected editor of the *International Journal of Leprosy* at the International Leprosy Congress in London September 16, 1968.

M. Mabil Rashad, recently from the University College, Dublin, Ireland, has been appointed Associate Professor in the Department of Genetics. Dr. Rashad is interested in cytogenetics, and will participate along with **Professor Jin Chung, Ph.D.**, and **Chai Bin Park, M.D.**, of the Department of Public Health (Medical Statistics), **Professor Fred Greenwood, Ph.D.** (Radioimmunoassay), and **Charles Nugent, M.D.** (Endocrinology), in postgraduate training for the University of Hawaii Joint Residency Training Program in Obstetrics and Gynecology.

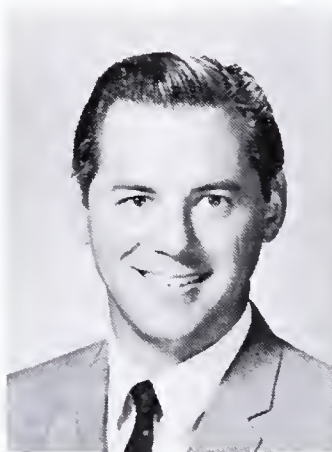
G. C. Ashton, Ph.D., Chairman of the Department of Genetics, recently attended the 11th Conference on Blood Groups and Protein Polymorphisms in Animals in Warsaw. **J. A. Hunt, Ph.D.**, Professor of Genetics, attended the 12th International Congress of Cell Biology in Brussels, and he presented a paper entitled "Synthesis of Nuclear and Cytoplasmic RNA in Fractionated Bone Marrow Erythropoietic Cells".

Edith Helen Anderson, Ed.D., will replace **Marjorie S. Dunlap** as Dean of the School of Nursing next semester. Dr. Anderson has been a nursing education consultant for the Children's Bureau since 1964. Her particular field of interest is maternal and child nursing which she learned at New York University, obtaining both the Master's and Doctor's degrees. ■



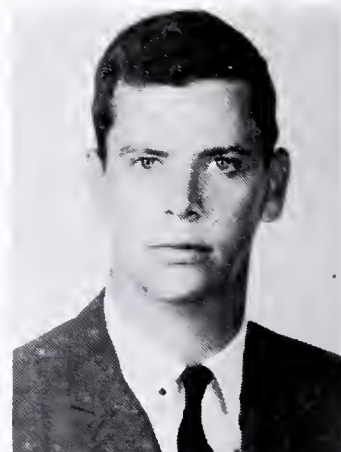
Philip Robert Foti, M.D.

30 Aulike Street, Suite 601
Kailua, Hawaii 96734
INTERNAL MEDICINE
Georgetown University—1961
Internship—Georgetown University
Hospital—1961-1962
Residency—Georgetown University
Hospital—1962-1963
Georgetown University Hospital—
1966-1968



Malcolm R. Ing, M.D.

1441 Kapiolani Blvd., Suite 612
Honolulu, Hawaii 96814
OPHTHALMOLOGY
Yale—1959
Internship—UCLA—1959-1960
Residency—Yale—1960-1963



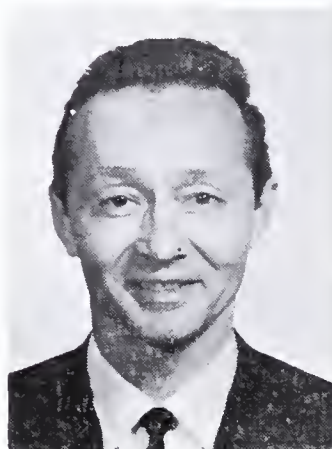
Charles B. Odom, M.D.

1133 Punchbowl Street
Honolulu, Hawaii 96813
OBSTETRICS-GYNECOLOGY
Tulane Medical School—1962
Internship—The Queen's Hospital—
1962-1963
Residency—The Presbyterian Medical
Center—1963-1964
Palo Alto-Stanford Hospital—
1964-1966



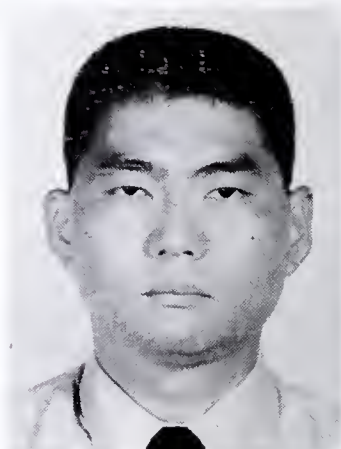
Robert S. Flowers, M.D.

888 South King Street
Honolulu, Hawaii 96813
PLASTIC SURGERY
Medical College of Alabama—1960
Internship—Tripler U.S. Army
Hospital—1960-1961
Residency—Cleveland Clinic
Hospital—1963-1968



David A. Johnson, M.D.

1374 Nuuanu Avenue
Honolulu, Hawaii 96817
ANESTHESIOLOGY
University of Colorado—1965
Internship—St. Francis Hospital—
1965-1966
Residency—University of Colorado—
1966-1968



Henry K. Watanabe, M.D.

1110 University Ave., Rm. 510
Honolulu, Hawaii 96814
PSYCHIATRY
Tulane University—1960
Internship—Womack Army Hospital,
Ft. Bragg, N.C.—1960-1961
Residency—Walter Reed General
Hospital—1961-1964

County Society News

Honolulu

Approximately 225 people attended the joint meeting with the Hawaii Bar Association on October 1. The following new members were welcomed into the Society: George Takushi, John Balfour, Walter Batchelder, Robert S. Flowers, Philip Foti, Ralph Hale, Malcolm Ing, David Johnson, and Charles Odom. The Treasurer reported on the improved financial condition resulting from the \$40.00 assessment. Dr. Boone urged the doctors to get in their Aloha United Fund pledge cards. Information was passed out on the Health Fair. Dr. Winfred Lee asked for the cooperation of the doctors in returning the physicians' reports after seeing a patient with a positive result in the diabetes detection drive. A panel consisting of Messrs. Martin Anderson, Walter G. Chuck, Myer Symonds, and Thomas M. Waddoups was moderated by Dr. Rowlin Lichter.

Approximately 137 members attended the November 12 meeting. A moment of silence was observed in memory of the late Dr. John William Devereux. The program, "Medical Education, Past, Present, and Future," was moderated by Dr. Winfred Lee. He reported on the intent of the HMA, which has taken the leadership in proposing a grant application to RMP for continuing medical education. The slate of nominations was presented, and several additions were made from the floor. The Bylaws Committee presented proposed amendments.

Maui

The August 27 meeting was held at the Wailuku Hotel. A discussion took place relative to an editorial in
continued page 246



John F. Balfour, M.D.

888 South King Street
Honolulu, Hawaii 96813

SURGERY

Washington University School of
Medicine—1961
Internship—Barnes Hospital
(Washington University Teaching
Hospitals)—1961-1962
Residency—Barnes Hospital
(Washington University Teaching
Hospitals)—1962-1966



Walter E. Batchelder, M.D.

P. O. Box 916
Hilo, Hawaii 96720
PUBLIC HEALTH

Boston University School of
Medicine—1939
Internship—Rhode Island Hospital—
1940-1942
Residency—Providence Lying-In
Hospital—1942



Ralph W. Hale, M.D.

888 South King Street
Honolulu, Hawaii 96813
OBSTETRICS-GYNECOLOGY
University of Illinois—1960
Internship—Akron General—
1960-1961
Residency—Kapiolani Maternity
Hospital—1965-1968



George M. Takushi, M.D.

1133 Punchbowl Street
Honolulu, Hawaii 96813
RADIOLOGY
University of Nebraska School of
Medicine—1964
Internship—The Queen's Hospital—
1964-1965
Residency—University of Oregon
Medical School—1965-1968

Medical Anecdotes

A Point of View. An ophthalmologist treated a famous artist and declined payment for his services. The grateful artist sent him a remarkable oil painting of a large human eye with the physician's face miniaturized in the pupil. The physician thanked the artist profusely and then commented, "Thank heaven, I am not a proctologist."—(Contributed by **Ed Childs**)

Oops, My Slip is Showing. A psychiatrist, apparently new in town, called the HMA office and asked for "either a Miss or Mrs. Lounge." He explained that he had received a HMA meeting notice and was trying to confirm the meeting date with a "Mabel Smyth Lounge." Our usually unruffled Phyllis Hashimoto took a full minute to compose herself before she could explain that the meeting was to be held in the lounge of the Mabel Smyth Building and that there really was no "Miss, or Mrs., Lounge."

Lee McCaslin wrote to Jean Holmes, editor of the *Garden Island*, thanking her for the use of one of our weekly HMA news releases in her paper, presumably to encourage her to use more of our releases. Jean, however, may have wondered about the intent of the following paragraph in Lee's letter: "If you keep your eye on them [meaning our news releases] you certainly will find more of interest. . . . Should you have any particular requests concerning Hawaiian health matters, do not let us know."

Queen's Death Conference. Four panelists brilliantly discussed "the case of a 47-year-old Japanese male with acute necrotic hepatitis" and arrived at four differing diagnoses. When **Roger Ogata** casually described the patient as "a social drinker," **Mort Berk** felt that the term "social drinker" was too vague, for it does not specify the number of drinks. **Ray deHay** contributed the observation that electron microscope studies reveal hepatocellular damage even with the first drink. Semanticist **Harry Arnold, Jr.**, objected to the term "male." He prefers "man" for an adult male and "woman" for an adult female. "Gentleman," he feels is much more personal than just plain male. **Mort Berk** referred to a recent article in "*Time Medical Journal*" which described the treatment of hepatic failure with a baboon's liver.

Kuakini Surgical Conference. Pathologist **Grant Stemmerman** had reviewed Kuakini's experience with breast cancer and reported an increased incidence of breast cancer in Japanese women. The mean age is 43, lower than for other racial groups, but the five-year survival rate was much better. Grant attributes this to the ease of early detection of breast lumps in Japanese women, who generally have smaller breasts. He is also unhappy about radical surgery for breast cancer, and does not feel that radical mastectomy is any better than simple mastectomy. He would rather recommend bilateral simple mastectomies than a unilateral radical. (We may also add that this makes for better balance as well.) During the ensuing discussion on therapeutic castration for breast cancer, gynecologist **Diek Sakimoto** felt that x-ray castration was better than surgical castration, whereas radiologist **Ed Childs** argued that surgical castration was superior. When cobalt therapist **Phil Lee** recommended

preoperative radiation for breast cancer surgery, **Grant Stemmerman** commented that we were seeing too many cases of radiation coronary insufficiency. Phil defended his stand that this was true with smaller x-ray machines, but that with cobalt, this was seldom seen. Grant ended the discussion with the terse comment, "I'm patient."

Notes from a Queen's Medical Conference. During a panel discussion on the use of pacemakers, cardiologist **Ed Chesne** (with his usual cigarette dangling from the corner of his mouth) turned to cardiac surgeon **Scott Brainard** and asked, "When is a surgeon called?" Scott replied, "Usually on weekends, when the cardiologist is not around. . . ."

Notes from the Annual Pathologists Meeting on Maui (Lahaina Room of the Sheraton-Maui). Contrary to prevailing concepts, we discovered the pathologists to be a fun lot. Before the evening slide session started, **Ann Catts** whispered happily to **Paul Tamura**, "Haver and Stemmy are not here. We should have a short session. . . ." **Art Saleedo** was the slide projectionist and the projector frequently went out of control, flashing the precious slides at the rate of one every few seconds. Paul, who had played 27 holes of golf that day, yawned happily, "That's one way of getting this conference over with. . . ." Neuropathologist **Hideki Namiki** stared at his fellow pathologists, who had misread his obviously vague slides, and remarked kindly, "The diagnoses were scattered. . . ." **Cliff Moran's** commentary can be sheer poetry: "I know one robin does not make Spring and one mitosis does not make carcinomatosis, but I would like to see at least one before I call it carcinoma. . . ." During the short business session, **Herb Uemura** was railroaded in as president and **Larry McCarthy** as secretary-treasurer. When **Paul Tamura's** loud snoring disturbed the proceedings, **Ann Catts** had to nudge him in the ribs. . . .

Visiting Physicians

Josef Warkany, the stocky, jowled, jovial "Father of Teratology" from Cincinnati, was lecturing on spina bifida at Children's Hospital. He was handed the remote control for the slide projector with which he was obviously unfamiliar. As he projected embryonic slides of the neural canal, he called out, "Next slide please. . . ." He gave an impatient sigh as he waited for the nonexistent slide projectionist to put on the next slide, when came the light of dawn and he remembered, "Oops, that's me. . . ."

Well-muscled, partly alopecic, authoritative visiting professor **L. B. Behrman**, from Louisville, Kentucky, gave brilliant lectures on renal pathology and treatment. He enjoys audience participation and called on dermatologist **Norman Goldstein** for his opinion of a microscopic slide of pathologic glomeruli. Norman hedged until fellow dermatologist **Dan Palmer** whispered the answer. L.B.'s endearing comment was, "I shall always remember Hawaii as the place where a dermatologist recognized periarthritis nodosa from a kidney slide."

During his lecture on dialysis, L.B. was asked about his criteria for patient selection. He admitted, "It is amazing how personal bias enters the picture. If the doctors like a patient, there is no end to the reasons that

can be found for dialyzing him, no matter what the risks." He was, however, optimistic that the emergence of home dialysis will change the need for selection criteria. For what it is worth, we learned that MADAM stands for Multiple Automatic Dialysis Mechanism. Regarding uremia, L.B. commented, "We don't know what the uremic toxins are, but we have faith that the coils will filter them out." During the discussion on cadaver renal transplants, L.B. stated, "When the cadaver dies, or when the cadaver becomes a cadaver, the cadaver himself has to be in good condition before his kidneys can be transplanted." (We had always assumed till now that cadavers were dead bodies, but L.B. seems to have given them life. . . .)

The visiting professor of surgery in December was tall, handsome, silver-haired **Rupert Turnbull** from the Cleveland Clinic. We caught his lecture on proclidentia (which is his own definition is a greater than two-inch prolapse of the rectum). "We don't like to operate on 85-year-olds, but they all want something done and they ask about the risk. I tell them, 'You won't have any trouble if nothing goes wrong.' This always reassures them. . . ."

Health Department

State epidemiologist **Bob Pennington, Jr.**'s periodic pronouncements make interesting reading. In June, he extolled the effectiveness of the measles vaccine. He pointed out that the 29 cases reported in Hawaii this year were "a mere drop in the bucket" compared to the five-year average of 263 cases reported for a similar period. He also reminded us that tetanus was not limited to children and adults, but oldsters as well. Of 235 cases of tetanus reported nationally in 1966, 152 were fatal and well over half of the deaths were in adults over 50. In Hawaii the pattern was similar. The ages of the fatal cases in 1967 were 2, 3, 75, and 76. In July, he reported that two island parrots were discovered to have parrot fever. Bob warned island physicians that the virus was here, but explained that it was not easily transmitted to man. He added that Hawaii, along with the rest of the nation, was experiencing the lowest incidence of acute illnesses in ten years. When Hong Kong flu news became vogue, Bob really went to town. In early September, he reported the first suspected Hong Kong flu case in a U. of H. student. He predicted that Hawaii should be hit first because of its proximity to Asia and Southeast Asia and warned of the possibility of a double flu threat, i.e., the A2 and the Hong Kong flu. In October, Bob reported confirmation of four Hong Kong flu cases from the National Communicable Disease Center where the specimens had been sent. **Walter Quisenberry** got into the picture at this stage, probably intending to keep the populace from panicking. He said, "There is no cause for alarm. People hear the phrase Hong Kong flu and think it is something alarming. Actually it is not much different from regular flu. The symptoms may include a headache, fever, and aches all over the body. There may be other symptoms like nausea and loss of appetite, but the disease usually clears up in a few days." (Patients who had the real Hong Kong flu may not quite agree with Walt.) In November, Bob reported that what we were seeing was probably an Asian three-day variety (another virus?) and it probably was not in epidemic proportions, but then on December 2, Bob reported that 53 cases of Hong Kong flu had been reported and 38 of these were in servicemen returning from Southeast Asia. Probably to shift the public attention from flu, Bob reported on December 12 that "from all indications, polio is 'pau' in Hawaii following the community-wide polio immunization in 1962." He felt that Hawaii's protected population added up to more than 80 per cent, and that when better than 80 per cent of a community is immunized, the disease is unlikely to occur. The Maui County Health Officer always makes



Look what was parked in front of a doctor's office, and a dermatologist's, at that!

news on Maui. In an open letter to the people of Maui (with particular reference to the health problems imposed by large groups of hippies) he stated, "Our policy is to promote good health by education, persuasion, demonstration, and execution, and not by coercion. Often times we apply reasoning and persistent persuasion, but never persecution, a most inhumane way of getting a good healthful environment." (Magnifico!) "Unfortunately, time does not permit us to handle the immediate education of the large increase of the outdoor-living newcomers [referring to the hippies], who know very little about hygiene and preventive health methods. . . . Rest assured that we are striving our utmost with all available measures to upgrade the environment of the hippies to conform with acceptable community standards." (We feel that such verbosity takes real talent.)

The Health Department's pediatric cardiologist has started a heart disease detection program for all public school fourth graders with a recently purchased phonocardiogram. Medical statistics suggest that one out of every 100 or 150 children have congenital or acquired heart conditions.

The National Council of State Governments recently suggested three new and stringent health laws pertaining to (1) the regulation of medical laboratories and personnel including licensing and inspection programs for all laboratories, (2) the training and licensing of all nursing home administrators, and (3) initiation of a program of identification tags for all meat animals to facilitate tracing and eradication of disease. **Wilbur Lummis**, Deputy Health Director, however, feels that Hawaii already has partial programs going in all three areas and no legislative proposals are in the offing to meet these standards.

VD Crusader **Richard Dang** had recently stated that 11,000 people in Hawaii have VD and that the rate of infection in Hawaii was 50 per cent above national average. **Ira Hirschy**, Executive Officer of the Communicable Disease Division, who disagrees, announced that a three-month survey completed in June may give a clearer picture of the total incidence of VD here. Ira says that the 11,000 case estimate is based on an arbitrary rule of thumb system which involves multiplication of reported cases by ten and doubling the result. (Higher mathematics?) In October, the Health Department reported that the VD rate on Maui had increased in the Lahaina and Haiku areas, which are known hangouts for the hippies. They also voiced a plea for the use of soap and water by the hippies because of an outbreak of serious staph infections among them.

Incidental intelligence: On December 6, **Walt Quisenberry** was home with a case of flu. So was **Ralph Berry**, Director of the County and State Hospital System. (It seems that even Health Department officials are not im-

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**Anatomy for Surgeons, Vol. 1
The Head and Neck, 2d Ed.**

By W. Henry Hollinshead, Ph.D., 619 pp., \$20.00,
Hoeber Medical Division, Harper & Row, 1968.

THIS LATEST EDITION includes the organs of special sense, and the only structure not covered in detail is the brain. The text is amply and well illustrated (485 illustrations). It is written well and easy to read in contrast to the standard textbooks of anatomy. In addition, there are brief descriptions of anomalies and pathological conditions, although the list is far from complete.

I recommend this book as a reference to surgeons involved with head and neck pathology. Students of anatomy may also find it useful for its wealth of references.

RAYMOND H. FUJIKAMI, M.D.

**Practical Automation for the
Clinical Laboratory**

By Wilma L. White, B.A., Marilyn M. Erickson, B.S.,
Sue C. Stevens, B.A., M.A., Ph.D., 401 pp., \$14.50,
The C. V. Mosby Co., 1968.

THIS BOOK DESCRIBES the basic theory and operation of some of the standard automated equipment commercially available for the clinical laboratory. Although the information presented can also be found in the service manuals prepared by the equipment manufacturers, these manuals are often difficult to obtain. This book will be a valuable training aid for students and technicians. The technical and operational information will also be of value to those contemplating purchase of automated equipment.

RICHARD R. KELLEY, M.D.

The Epidemiology of Hypertension

*Proceedings of an International Symposium, Edited by
Jeremiah Stamler, M.D., Rose Stamler, M.A., and
Theodore N. Pullman, M.D., 472 pp., \$17.50, Grune
& Stratton, 1967.*

THESE ARE TRANSCRIPTS of a symposium sponsored by the Chicago Heart Association and the American Heart Association in Chicago in 1964. Experts in hypertension from all over the world discuss the problems and the various approaches possible from an epidemiologic point of view.

Though the book is quite interesting to people interested in hypertension, it deals not at all with the work-up for hypertension, treatment, etc. Its only interest is in the revelations about essential hypertension made possible through epidemiologic analysis of populations.

Because of this approach, the book is of little value to the general practitioner or internist, but rather to those who do clinical research in essential hypertension.

Among the many points of interest brought out, is that hypertension is a greater risk factor in coronary artery disease than is heavy smoking.

However, the over-all value of the book and its relatively large cost makes its enthusiastic audience a small group; that is, those specifically interested in the epidemiology of essential hypertension and those who intend to do clinical research in this sphere.

EDWARD L. CHESNE, M.D.

★ means highly recommended.

Harold G. Wolff's Stress and Disease, 2d Ed.

By Stewart Wolf, M.D., and Helen Goodell, B.S., 277
pp., \$10.00, Charles C. Thomas, 1968.

IN THIS SECOND EDITION of Harold G. Wolff's work, the authors have wisely and with deference not attempted a revision of this classic work, but rather have added new data and insights which have been gathered in the last 16 years since the book was first published. Many samples of investigative efforts are reviewed, thus making for swift perusal and giving the reader a comprehensive look at the broad continuum of research efforts in the field of stress and disease. There are excellent and extensive bibliographies at the end of each chapter.

The relations between body systems and stress are discussed, and the ensuing discussion makes clear the artificiality of the "mind-body" problem and the inherent semantic difficulties in trying to classify disease in terms of "organic" or "functional." An important theme of the authors is that man is constantly in need of adapting to stress in his environment, and these stresses may be physical or symbolic, and in the failure of adequate adaptation lies the path to disease. Those readers familiar with the first edition of this work will be interested in knowing that major additions in this book have to do with attempts to synthesize and formulate some of the observed data to include consideration of the organization of reaction patterns and to look at patterns of social adjustment and disease. The nonpsychiatric physician should find Dr. Wolff's discussion of the therapeutic process especially informative.

KWONG YEN LUM, M.D.

★Dilemmas in Drug Therapy

By Harry Beckman, 404 pp., \$11.50, W. B. Saunders
Co., 1967.

THIS LATEST BOOK from a most skilled writer in the field of therapeutics is most welcome. In it are some 375 pages of questions and answers arising from Dr. Beckman's new situation as a consultant on drugs to the various hospitals in his area.

A sample of questions and the essence of the answers gives a good idea of the content of the book:

Question: Is it true that hepatic impairment has resulted from the use of the contraceptive pill? Reply: Dr. Beckman has seen two reports of such in postmenopausal women and two others in younger women, but the latter had had previous jaundice. Five references are then briefly given.

Question: What is the preferred chemotherapeutic agent in chronic granulocytic leukemia? Reply: Busulfan (Myleran) appears still to hold this position.

Question: What can be accomplished with the rauwolfia preparations in hypertension and what are the dosages of the several preparations and the side actions? Reply: Dr. Beckman says that these preparations are helpful in mild, but have little value in severe, hypertension, and then gives a detailed statement of practical therapeutics.

Question: If a woman with thyrotoxicosis has been treated throughout her pregnancy with antithyroid drugs should the infant be allowed to nurse? Reply: No.

The subject matter is indexed in detail at the end of the book and also arranged alphabetically throughout

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The Pathfinders

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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: EDITH G. EKSTEIN, MT(ASCP), U. S. Army Tripler General Hospital

Medical Technology and the Future

Is it time to change our goals? Are we headed the right way on the wrong road? To what new requirements must medical technologists be prepared to adjust? This month we're looking at the future from the perspective of the clinical laboratory, the college campus, and HSMT.

Changing Requirements in the Medical Laboratory

In the next five to ten years, hospital laboratories will require better educated, highly skilled, and well-trained medical technologists to perform the many laboratory tests for an increasingly health conscious public. The training program for medical technologists must be able to meet this demand by adjusting its requirements as each class of interns begins the year of training. Laboratory technology is developing rapidly and significantly. Results of the ASCP Registry Examination should be studied for necessary improvements in the training program. Technologists who teach at the bench or in the classroom must continually upgrade their own education in medical technology. It is the responsibility of all medical technologists involved with training to realize the importance of a well-planned, progressive internship program.

A brief rundown of requirements for each phase of medical technology training is given here and is not intended to be complete.

Hematology is gradually being automated without abandoning the basic manual and visual techniques of identifying blood cells. The varying effects of drugs on blood cells are a challenge. Knowledge of genetics is important in the study of hemoglobin and hereditary blood disorders. Biochemistry and physiology are basic for both hematology and *urinalysis* training. *Clinical chemistry* training will require courses in basic electronics, physical chemistry, chromatography, gas chromatography, and biomedical instrumentation. *Bacteriology* training is putting emphasis on a good background in practical medical bacteriology and in biochemistry in order to identify microorganisms rapidly. Research involving gas chromatographic patterns may help identify certain bacteria in the same manner as other unknown material is identified at present. *Immunohematology* training requires courses in genetics, immunology, and biochemistry. *Parasitology* training is

assisted by practical laboratory technique in identification of parasites and handling of specimens. Training in *serological* techniques is facilitated by a good background in immunology and biochemistry. With steadily improving techniques and readily available products, training requirements can be met. *Fluorescent antibody* techniques are already part of the training program in some hospitals. *Histologic* technique, while seemingly unimportant, will remain helpful and necessary to the student in understanding staining reactions and in handling material to be stained and permanently mounted. It is hoped that the gap between college and training will be narrowed considerably by efforts to satisfy these requirements.

The technology of laboratory medicine can only be understood by those who have a good command of English. This is true of any technical profession. Politics, speech, and semantics play important roles in this generation of confrontation. Technologists must be able to speak and write intelligently throughout a demanding, finely detailed, daily work schedule. They must communicate with nurses, patients, doctors, visitors, bosses, employees, students, and the general public. Technologists must know how to give clear instructions to others and to interpret written procedures and orders. Technical literature in professional journals is meaningful to those who comprehend well and is further enhanced by a course in speed reading. Written expression covers the gamut from a memo left for the next shift to a laboratory examination for a student. For those who are in a supervisory or administrative capacity, there are job descriptions, laboratory manuals and procedures, rules and regulations, correspondence with applicants or laboratory suppliers, in-service training, orientation of new employees, personal interviews of job applicants, handling of complaints, and interdepartmental communication.

Technologists will need training and courses in the business aspects of a modern laboratory. Many functions of the laboratory depend upon procurement of numerous items, repairs and proper maintenance. Projections of equipment needs, cost accounting, budgets, mechanics of purchasing, transportation problems, and service contracts are important facets of laboratory business. Added to all this is the advent of computerization in the hospital field and the tremendous possibilities and responsibilities of this sophisticated system.

A medical technologist must also change his intellectual as well as his professional require-

ments. He may be a professional but he should be an interesting one. To achieve this, he needs a balanced, well-rounded education and continuous intellectually stimulating activities.

A medical technologist is a true professional provided he conducts himself as such. He can no longer hide in the laboratory to do his work in ways mysterious to the public and even medical personnel. He can no longer be just a CBC-and-Urinalysis "laboratory technician." He needs to improve himself in many respects in order to meet the changing requirements in the medical laboratory.

LORENE LEONG, M.T. (ASCP)

Professionalism—One Way To Get There

"Current trends in the clinical laboratory point to the need for advanced study in several areas to carry out the growing roles of the medical technologist as administrator, educator, researcher and/or specialist," states the foreword to *Guide to Graduate Programs for Medical Technologists*, just published by the National Council on Medical Technology Education. The guide was produced in connection with educational activity funded by a grant from the Cancer Control Program of the U.S. Public Health Service. The Council is affiliated with the National Committee for Careers in Medical Technology, which has operated for some 15 years to promote careers in the medical laboratory.

The publication is the result of detailed research and provides a guide to 126 colleges and universities offering graduate programs of interest to medical technologists. It classifies admission standards of the institutions as "very competitive, competitive, or selective," names the fields of study offered, such as bacteriology, biochemistry, education, anatomy, and details the financial aid, if any, available to graduate students. An appendix lists universities offering graduate programs in medical technology.

While the guide does not claim to be a complete record of all information on graduate programs a medical technologist might want, it is the first compilation of this type of information ever made available in the field.

The Guide may be obtained from the National Committee for Careers in Medical Technology, 9650 Rockville Pike, Bethesda, Maryland, 20014, for \$1.00 to cover printing and mailing costs.

The above release from NCC MT is proof of the realization of need for advanced education for Med Techs. This, in turn, is a reflection of the growing professionalism of medical technology as a career. The concept of MT education being "trade school training" is given the lie by these 126 graduate programs.

The University of Hawaii has plans for a graduate curriculum in medical technology with the

Master's degree granted by the Department of Pathology. In the meantime, as preparation for the advanced program, courses have been established in med tech or microbiology which will ready the student who anticipates going on for a higher degree. Such courses as Advanced Hematology, given a year ago, Review of Biochemistry, given last spring, and the upcoming Immunology course are the kind of courses designed not only to bring working Med Techs up to date on new concepts but which also serve to bring him back to the role of "student."

One of the problems with the older Med Tech coming back to school for advanced work is the generation gap! Not that anyone over 30 is to be distrusted, but maybe his basic knowledge of biochemistry or immunology should be (distrusted, that is). For anyone planning on returning to school to work on a Master's degree, courses in these areas, if taken before coming back full time, not only save time but provide a preview of things to come. Depending on one's area of interest, graduate school can be almost impossibly difficult for the older Med Tech. This is partly because of the many new theories and concepts discovered within the last ten years and also because of the difficulty in returning to formal, full-semester academic course work. Not to belittle the great value of continuing education workshops and short seminar courses most Med Techs attend, but they do not quite prepare one for the rapid, crammed, and competitive regular course work at an advanced level.

The goal of the Med Tech department along with the Hawaii Society of Med Techs is to insure that at least one credit course is offered in a year. Thus, anyone who has taken the three-credit courses above mentioned and has done reasonably well, can feel confident of going ahead for his advanced degree.

There are those who say "And what will an advanced degree mean to me—how will it benefit me?" One of the signs of the professional is that he does a thing because of an inner drive that says, "I *must* know more; I must be able to do more—I can't stand not understanding!" Just as a professional artist perfects his acting or performing or painting technique because he *must*, whether or not he gets the great role, plays Carnegie Hall, or sells his pictures, so a scientist learns because he *wants* to know.

To keep up with the changing laboratory, old ways of training are being changed; in spite of automation and computers, knowledgeable men must be there to design the tests to trouble-shoot, etc. Our role as technologists may change technically and as professionals, we will do just that to better serve the physician and ultimately the patient.

LOUISE M. WULFF, MT (ASCP)

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1. Harkins, R. W., and Sarett, H. P.: J. Nutrition 91:213-218 (Feb.) 1967.

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Mead Johnson
LABORATORIES

Hobdy resigned from the USPHS to enter private practice and Dr. Ramus became chief of the Quarantine Service. In August, 1911, the doctor was licensed to practice medicine in the Territory, but was never to avail himself of this privilege.

Dr. Ramus was transferred to Port Townsend, Washington, in April, 1912, where he remained for a short time before being sent to New York. On his way to his new assignment, Dr. Ramus stopped in Chicago where he married Miss Anna Wood Tucker of Honolulu on September 27, 1912.

During the years that followed, Dr. Ramus served at numerous posts, among which were Washington, D.C., Boston, and New York City, and attained the rank of Surgeon. On his retirement from the USPHS, he settled in New York City and went into private practice, specializing in psychiatry. About 1944 he was on the staff of the New Jersey State Hospital at Trenton. Later he returned to New York and private practice. On retirement from active practice, he made his home at Alexandria, Virginia.

Dr. Ramus died in Washington, D.C., December 7, 1963, at the age of 91.

During his Honolulu years he was an active member of the Hawaii Medical Society and presented several papers before the group. A valuable addition to the musical circles of Honolulu, Dr. Ramus played the viola and was a member of the Honolulu Symphony Society. ■

Notes and News continued from 229

mune to flu. We wonder if they had taken their flu shots as they had recommended?)

Entrepreneurs

Kazuo Miyamoto's excellent historical-autobiographical novel *Hawaii—End of the Rainbow* is now available in a pocket book size. **Ted Hart**, Straub Clinic physician, has written a book *Banzai—A Surfer's Hawaii*, illustrated with 48 photos of surfing conditions, including one showing surfers riding the waves with sharks. Ted says, "Islanders do not brag when they say they have the biggest, most versatile, most consistent surf anywhere in the ocean."

L. Q. Pang and **Don Poulson** headed the Doctors for Nixon finance committee. In December, four Diamond Head lots went on sale. Allergist **Alan Young** bid \$52,000 for Lot 33 (10,707 sq. ft.) on Pokapahu St.

Hors de Combat

When the **Ira Hirschys** returned in early November to their Tantalus home after a month's absence during which they attended a London conference on Hansen's Disease, they discovered their home ransacked and \$10,000 worth of belongings missing, including almost anything portable (i.e. all furnishings and even the grand piano). Neighbors saw moving vans coming from their driveway on two occasions, but thought the Hirschys were "just moving something" because the Hirschys had

not informed them that they would be gone. Police investigation revealed that over 30 teenagers had engaged in the looting, and had apparently used the home as a hippie hangout. Several arrests were made and some of the items recovered.

Honolulu neurosurgeon **Maurice Silver**, who is suing three Honolulu hospitals and some fellow physicians for \$1.5 million, has engaged **George T. Davis**, who defended **Caryl Chessman**, and also **Andrew C. Ivy** in the **Krebiozen** trial. Maurice is suing **Queen's Medical Center**, and **St. Francis** and **Kuakini** hospitals, their hospital administrators, and three neurosurgeons for allegedly conspiring to keep him from admission to the staffs of these hospitals.

Community Notes

The Aloha United Fund has again met its quota for 1969, with \$4 million in cash and pledges. The poorest division was the professional division with the physicians at the very bottom, with \$23,895, or 69 per cent of their modest quota of \$34,000. For shame, fellows!

Children's Hospital ended the fiscal year with an operational deficit of \$57,000, but was able to break even with gifts and investments. Statistics released by the Health and Hospital Planning Council show that **Children's Hospital** with a bed count of 73 had a 59 per cent occupancy rate in 1967, which is higher than the overall pediatric bed rate of 41.75 per cent for the four general hospitals which still had a pediatric service in 1967. A Labor Department report reveals that since 1946 hospital room rates have skyrocketed by 354 per cent and doctors' fees have risen by 107 per cent. This compares with the 71 per cent rise in over-all living costs.

Max Botticelli of the Medical Group presented \$1,000 scholarships to two students at the University's College of Health Sciences and Social Welfare in behalf of the Medical Group Research Foundation. The scholarships are named for **James R. Judd**, **Nils P. Larsen**, **Francis J. Halford**, and **A. V. Molyneux**, the four founding members of the Medical Group.

The first summer camp for diabetic kids was held in July at Camp Erdman with two full-time MD's (**Willard Miyahira** and **Francis Ikezaki**) and three nurses. This was a joint project of the YMCA, the Hawaii Medical Association, the Nurses Association and the Dietitians' Association.

An estimated 100,000 persons attended the three-day **Hawaii Health Fair** at HIC. The cost was estimated at \$115,000. The major source of funds was \$50,000 from the State Legislature, \$33,000 from the Public Health Committee of the Chamber of Commerce, \$20,000 in contributions from physicians, and \$12,000 in other donations from major health agencies, private foundations, and corporations.

The University Medical Service (UMS), in St. Francis Hospital, is supervised by the University Medical School and the hospital medical staff. The service, which provides inpatient and outpatient care, is housed in a 20-bed nursing unit. **Dick Blaisdell**, Chairman of the School's Department of Medicine, says, "The practice of medicine is becoming increasingly complex. No longer is one practitioner expected to know what there is to know about all cases that come to him. Better team care is often demanded for diagnosis and treatment. Private physicians may refer their patients to UMS, but the majority of the patients in the unit now are staff cases, including Medicare patients and medical indigents."

The Waimanalo Child and Youth Health Services Center was established last May to provide free diagnostic health care for all children from birth to age 16 and is a Federal and State financed project administered by the Department of Health. When the project clinical director resigned in November "to avoid personality clashes," the Waimanalo residents were up in arms and demanded to take part in policy-making decisions. They were reassured by **Harry Shirkey**, Medical Director of Children's Hospital, and **Louise Childs**, Chief of the Maternal and Child Health Division, that pediatric care

will continue to be available with staff pediatricians from Children's Hospital and a part-time private physician.

Patrick Cockett, new Kauai member of the University Board of Regents, was under fire from critics. He had convened a 15-member committee meeting which decided to change the location of the new Kauai Community College from previously suggested Lihue to Wailua. Critics assailed the change in site, but the real issue was the manner in which the committee was maneuvered into recommending the new site at its first and only meeting, held without advance notice. The press was peeved too, because it was barred from the meeting.

We were saddened by the untimely death of **Ralph Platou** who, before leaving in June, was Medical Director of the Children's Hospital and Professor of Pediatrics at the U. of H. Medical School for 1½ years. Ralph died on September 15 in Radnor, Pa., at age 58, from Hodgkin's disease and a recent myocardial infarction. He had left Hawaii to become Executive Secretary of the American Board of Pediatrics. During his productive stay in Hawaii, the Children's Hospital program "became geared towards emphasizing the multidisciplinary approach—integration of all professions concerned with total child care." A Ralph V. Platou Memorial Fund, established at Children's Hospital, will be administered by the hospital trustees to perpetuate his memory in pediatric education and for the care of children.

Civic minded **Mor J. McCarthy** often speaks his mind. During a public hearing on a proposed ban on surfing in two areas of Kailua Beach by the State, Mor argued that the proposal would "crowd swimmers into small areas and lead to problems of refuse disposal, public health, and parking." (We too fail to see the correlation.) Again during the Mayor's annual safari to Windward Oahu to talk to residents about their problems, Mor had a problem. He felt that there were inadequate supervised recreation areas in Kailua and that teenagers were attending "odd parties." Mor alleged that the youngsters

were being "led astray by ultra-liberals and radicals, and running through residential areas late at night." He successfully aroused the Mayor, who was sharply critical: "This is not the responsibility of the City-County government. This is the responsibility of the mothers and fathers of this community. . . ." Now that's something we hadn't thought of.

Dick Ando, Chairman of the Board of Education, was aroused by Raymond Corsini's remarks on the drop-out prevention program. Dick pointed out that we have one of the nation's highest retention rates. Without mincing any words, he wrote: "There is a continuing attempt to gain public notoriety by whipping an old reliable work-horse with generalities and with uninformed criticisms when a new breed is beginning to take its place. . . . May I suggest to well-meaning citizens that they try to get acquainted with the new direction of the public schools before grinding their axes and taking wild swings, for whatever cause, at our dedicated professionals who serve our schools and our children. . . . Why undermine the confidence our people have in the many good things our teachers and schools are doing for our children?"

During Poison Prevention Week, **Dick Ho**, director of the Poison Control Center at Children's Hospital, effectively pointed out: "It is paradoxical that accidents, the number one killer of children, have no cure. . . . Before we can find a cure, we would have to understand the dynamics of this disease. Accidents do not just happen; they are caused by a sequence of events. . . . Parental lack of understanding of what is expected of their child has been responsible for 87 per cent of cases. . . . A toddler is highly susceptible to accidents; 4,800 die each year from accidents. . . . The 'vaccines' for accident prevention are protection and education." In the wake of the death of a 16-year-old girl from Hickam AFB, Dick warned that young "fume sniffers" are on the increase throughout the State and are using a wide variety of aerosol agents—from hair spray to paint and varnish sprays. Soon after inhaling the fumes, the inhaler has

continued page 238

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double vision, ringing in the ears, slurring of speech, physical uncoordination, and hallucinations. . . .

A Hilo GP who recently spent two weeks at a Honolulu Hospital (whom we have reason to suspect to be our HMA President) gave his observations as a patient. The experience gave him a new outlook on patient care and hospitalization. He was very appreciative of the nurses and his physicians. He was, however, introspective about the food. "It might have been me, or it might have been the food. But toward the end, I was beginning to tolerate it. . . . When I have patients in the hospital, I'll be a little more sympathetic to their complaints and suggestions."

Elected, Appointed and Honored

The following eleven local surgeons were initiated as Fellows of the American College of Surgeons: **H. William Goebert, Jr.**, **Gerald Faulkner**, **William Hindle**, **Edward Izawa**, **Robert Kistner**, **Albert Kong, Jr.**, **Robert Peyton II**, **Millard Seto**, **Walton Shim**, **William Won**, and **Roger Brault**. They were later honored by the Hawaii Chapter of the American College of Surgeons, whose new officers are: President, **Gil Freeman**; Vice President, **Grover Batten**; and Councillor, **Sam Yee**. **Dennis Fu**, now of Wailuku since his military discharge, was elected a Fellow of the American Academy of Pediatrics at its recent annual meeting in Chicago. **Cal Sia** was named Chapter Chairman of the American Academy of Pediatrics and appointed to the Academy's Committee on School Health. **Harry Shirkey**, Medical Director of Children's Hospital, was appointed to the Committee of the Section of Pharmacology of the American Academy of Pediatrics and was reappointed to the AMA's Council on Drugs. **Windsor Cutting** was

recently honored by being included in *World's Who's Who in Science from Antiquity to the Present*, published by the Marquis Co. of Chicago. Kuakini Hospital elected **Roy Tanoue** as one of its five new directors and Children's Hospital reelected **Harold Sexton** as trustee. **Dick Ando** was recently reelected Chairman of the State Board of Education. We were happy to see **Dudley Seto** selected as one of the three Outstanding Young Men of the Year by the Hawaii Junior Chamber of Commerce. Because of our long training period, we have difficulty showing any real accomplishments before age 35, the age limit set for qualifiers of this award. We must congratulate **K. S. Tom** for his recent election as Honolulu County Society president, succeeding **Herbert Chinn**, who did an outstanding job. In his inaugural speech, K.S. warned fellow physicians that the Federal Government is an all powerful agency that has helped the poor and underprivileged who "never had to lift a finger to help themselves. . . . We must now become involved in the entire socioeconomic structure. We cannot afford to revert to the 1920's, nor can we accept the status quo. . . . If we don't become involved, someone else in government is bound to do it for us, isolating and bypassing the medical profession." K.S. identified the government's increased movement into the realm of social welfare as New Deal Liberalism. He promised that the Society will "activate and expand our involvement in socioeconomic activities, especially those relating to the practice of medicine." (Simply magnificent. Now all we need to do is stop our bickering and carry this out.) The other newly elected county presidents are **Hal Lewis** of Hawaii, **Albert Johnston** of Kauai, and **John Morris** of Maui.

Professional Notes

We have noticed that few physicians make their moves at the end of the year. The mavericks this year were the
continued page 240

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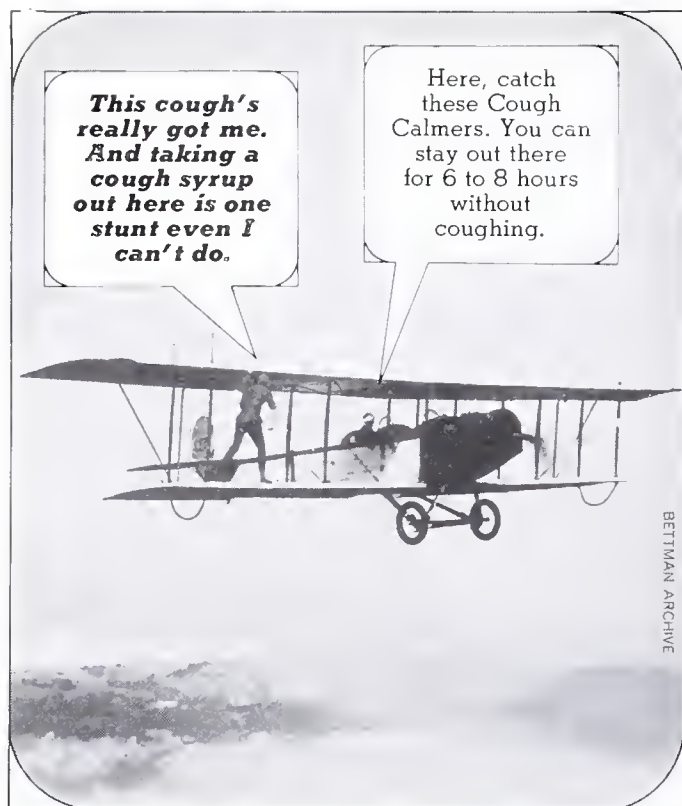
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following: In October, GP **Norberto Baysa** relocated to the Medical Arts Clinic at 606 Kilani Ave., Wahiawa, and radiologist **Peter Claremont** opened at the Kailua Professional Center. Footloose psychiatrist **Lynn R. Woodward**, who served in four different states before arriving here, is the new staff psychiatrist at the Diamond Head Unit of the State Hospital. In November, general surgeon **John Withers** opened at 1837 Wells St., Wailuku, Maui, and we were happy to see pediatrician **Toshihiko Kawasaki**, who vacillated for several months on where to roost after his discharge from military service, finally settled at the Medical Arts Bldg.

Sportsmen

We read *Advertiser* sports editor Hal Wood's account of **Mort Berk's** ordeal in Mexico City where he watched his son Brent swim in the qualifying rounds of the 400 meters freestyle. Hal writes, "When it was over, Brent was puffing easily enough, but his dad was a human dish rag. He looked like he had just given birth to an 18-pound baby." (We wonder if sports editors should not take time out to review some basic human physiology.)

Turf Diggers: In October at the WCC, **Sam Yee** won A flight stableford and **Paul Tamura** B flight. On another weekend, **Tom Fujiwara** was 4 up in B flight and **Kiku Kuramoto** and partner won team low net. At Mid Pac, the team of **Henry Yokoyama** and **Frank Fukunaga** tied in team best ball (with Frank doing all the work). In November, durable **Sam Yee** again paced A flight and **Al Ho** B flight. At OCC, **Marquis Stevens** and partner tied with two other teams for team best ball. At Mid Pac, **Dick Omura** won in stableford. At WCC, **Toru Nishigaya** and partner won team stableford. We learned that the latest golf "hot shot" at Mid Pac is **Catalino Cachero**, who has been winning every weekend in December. Mid Pac "Ringer" **Al Paraz** has found the mud not to his liking.

Fishermen: **Harold Sexton** was installed as fleet captain for 1969 for the Kaneohe Yacht Club.

Other Sportsmen: We again read Hal Wood's account of a sporty personality. "**Dr. Richard You**, the nonstop talker and sparetime fight manager, has been slaving away the past week at Las Vegas. Now this takes a good deal of doing . . . to slave away at anything but gambling at Las Vegas. It takes a strong constitution to handle the free booze and the ability to go without sleep forever and a set of 20-20 eyes to ogle the girls as they go wiggling by. Dr. You writes, 'The night life and the long hours are hard on the nerves and the heart. We have meetings all day that last until 2:30 in the morning as the AAU attends to its business. This is a city of lights, happiness, and often depression. I am attending the national AAU convention as a delegate and I am happy to state that we are working very hard without pay.'"

J. I. F. Reppn of Kaneohe traveled 6,000 miles to see his son play his last collegiate football game at Hamilton College in Clinton, N.Y. **Daniel Whang**, team physician for the Leilehua football team for the past 15 years, was honored on his retirement at a pep assembly recently and presented with numerous gifts and a lifetime pass for all Leilehua games.

Yachtsmen: Waikiki psychiatrist **Ellsworth Harris** "psyched" Hawaii Yacht Club's racing fleet recently by winning the final event in the club's point championship for the class A flight with his 34-foot sloop "Premier." He took five firsts and three seconds in the best eight out of thirteen races.

Bulletins

The **American Electroencephalographic Society** and Baylor University College of Medicine will sponsor a course in "Current Problems in Electroencephalography: Advances Toward Their Solution" in Houston, Texas, on

continued page 244

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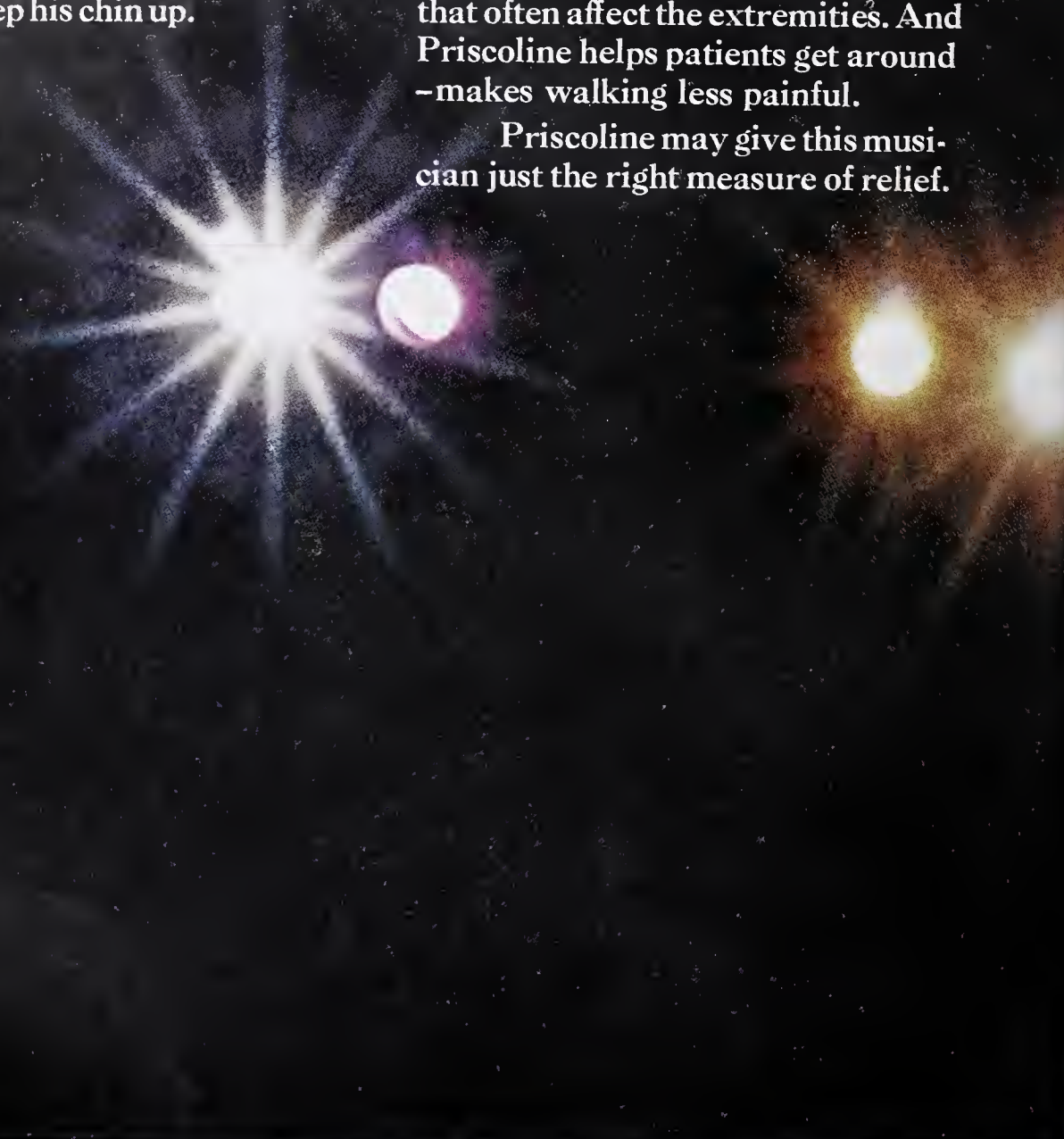


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March 13 to 15, 1969. Further information can be obtained by contacting Dr. Peter Calloway, Baylor University College of Medicine, Texas Medical Center, Houston, Texas.

Joe Oren is chairman pro tem of the Hawaii Allergy Society which is being organized to advance knowledge and practice of allergy and promote education and research in the specialty. The Society is open to all interested physicians.

The 11th Congress of the Pan Pacific Surgical Association will be held here in Honolulu from October 14 to 22 (following the meeting of the American College of Surgeons in San Francisco, October 6 to 10). The scientific program will consist of some 300 speakers in all surgical specialties. All scientific meetings are scheduled for the morning.

The American College of Surgeons has scheduled three sectional meetings in 1969: February 3-5 in Omaha, Neb.; February 23-26 in Louisville, Ky.; and March 10 to 12 in Boston, Mass.

NEWS

Cancer Family Syndrome Study

The Medical Genetics Section of the Department of Preventive Medicine and Public Health at Creighton University School of Medicine, Omaha, Nebraska, is interested in the study of patients showing an increased incidence of any histological variety of cancer in their families. Of particular interest to us is the cancer family syndrome, characterized by: (1) increased frequency of adenocarcinoma of all sites, particularly of the colon and endometrium, (2) early age at onset of cancer, (3) increased occurrences of multiple primary malignant neo-

plasms, and (4) autosomal dominant inheritance. To date, we have investigated six families fulfilling all of the above criteria (Lynch, H. T., and Krush, A. J.: Heredity and Adenocarcinoma of the Colon, *Gastroenterology* 53:517-527, 1967), and have corresponded with physicians in Europe who have described two separate and unrelated families which also fulfill the above criteria.

Physicians, with patients known to have a familial cancer background, may write to Henry T. Lynch, M.D., Associate Professor and Chairman, Department of Preventive Medicine and Public Health, Creighton University School of Medicine, 657 North 27th Street, Omaha, Nebraska 68131.

We invite your cooperation in our studies which will include a genealogical and medical investigation of the entire kindred in each case. All information obtained will be shared with family physicians in order to facilitate cancer control.

Book Reviews continued from 230

the book, so that one has little difficulty in tracing down comments in any desired field. The book is sure to give pleasant and informative reading for doctors, young and old.

WINDSOR C. CUTTING, M.D.

Laboratory Manual of Pediatric Microbiochemical Techniques, 4th Ed.

By Donough O'Brien, M.D., F.R.C.P.E., Frank A. Ibbott, Ph.D., F.I.M.L.T., and Denis O. Rodgerson, M.S., F.I.M.L.T., 367 pp., \$11.90. Hoeber Medical Division, Harper & Row, 1968.

THE AUTHORS should be complimented for their efforts on their latest edition of this already popular laboratory manual. What started out as a mere compilation of

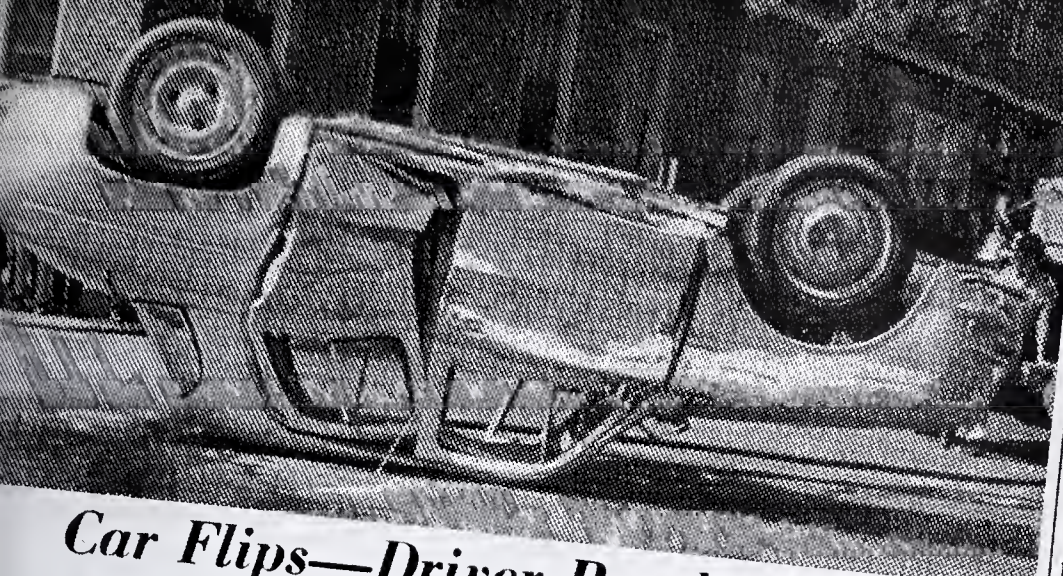
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STAFF PHOTO

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the July 24 *Maui News* and all doctors were reminded to report communicable diseases and to keep their own record of reported cases. It was decided to postpone a meeting with Maui's legislators relative to possible changes in the Medical Practice Act until after the HMA develops a stand on the examination of osteopaths. HMA committee appointments were discussed and the advisability of changing county appointments so that they would become effective mid-year was mentioned. A desire to cooperate with Hale Makua and a family care program was expressed. The president gave an interim report on the exploration to consolidate hospitals in Maui County. Doctors were urged to display Foundation plaques in their offices and were advised that the Maui Electric Company now covers its employees under this plan.

At a special meeting on August 29 the following new members were elected: Denis J. Fu, Kenneth McCollum, Paul Larive, and C. Arthur Rossberg.

The November 19 meeting was held at the Maui Frontier Hotel. Inasmuch as there was not a quorum, no official action was taken. A press release from Hale Makua on the services provided was approved. It was suggested that the number of members required for a quorum be reduced. A report was given by Dr. Iaconetti on HMA Council actions. Dr. Wong reported on the Diabetes Survey. It was felt that the site and manner of the testing was a deterrent in getting people to participate. A newspaper article involving one of the members was discussed and it was agreed that the press should be advised of what represents ethical reporting. The meeting closed with a talk by Dr. Masato Hasegawa on the Regional Medical Program.

A special meeting was held on November 21. Drs. Kenneth Christensen and John N. Withers were elected to membership. The former is a transfer from Honolulu and the latter's membership will become effective January 1.

The following were elected for 1969: John F. Morris, President; Clifford F. Moran, Vice President; C. Arthur Rossberg, Secretary-Treasurer; Sakae Uehara, Louis S. Rockett (holdover), HMA Delegates; Edward B. Underwood, J. Mark B. Sowers (holdover), HMA Alternate Delegates. ■

"recipes" for the bench technician has now grown up into a really valuable source book for the clinical chemist, advanced technologist, and the laboratory director for most of the microchemical procedures that would be required of a pediatric laboratory service. This has been accomplished by an expansion of the clinical and technical commentaries, now accompanied by a list of pertinent references. The commentaries are very well written, concise, and up to date. The technical comments should be especially useful to the chemist in his consideration of the relative merits of available procedures.

This extensively revised edition has also been improved by the addition and expansion of procedures for the diagnosis of the various inborn errors of metabolism.

Only one minor weakness remains. The table of contents is really an abbreviated alphabetic index which is difficult to follow. This weakness should not detract from this otherwise excellent technical and reference manual for all workers interested in pediatric microchemistry.

HERBERT S. UEMURA, M.D.

★Clinical Endocrinology

By Edwin B. Astwood, M.D., and Carl E. Cassidy, M.D., 844 pp., \$29.75, Grune & Stratton, 1968.

THIS TEXT is highly recommended for the clinical endocrinologist and all practicing physicians interested in endocrinology. Advances concerning new feedback mechanisms of the hypothalamus, radioimmunoassays, therapeutics, physiology, etc., are of immense value.

In summary, this superb textbook is highly recommended and should be considered to be authoritative, stimulating, and enlightening to most clinicians.

WINFRED Y. LEE, M.D.

Also Received

The Interview in Student Nurse Selection

By C. H. Smeltzer, Ph.D., 185 pp., \$6.00, G. P. Putnam's Sons 1968.

A VALUABLE GUIDE FOR THOSE in nursing education as well as those involved in the selection of medical personnel.

Principles and Practice of Podiatry

Frank Weinstein, D.S.C., F.A.C.F.R., Editor, 508 pp., \$22.50, Lea & Febiger, 1968.

A COMPREHENSIVE TEXT OF podiatry which may be of interest to physicians curious about this form of therapy. ■

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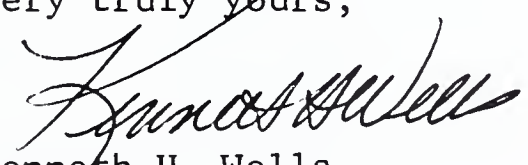
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May we congratulate you on the vast strides the Doctors Business Bureau of Hawaii has made in its initial three months of business and as such we are most happy to have been associated with your success.

If there is any way in which we may be of further service either to you or the medical profession in the data processing and computer field, please feel free to call on us.

Reiterating our best wishes for your continued success, we are

Very truly yours,


Kenneth H. Wells
Vice President/General Manager

*For your
Confidence - Our
Sincere Thanks
P.R.*
KHW/mma

Our "Angels"

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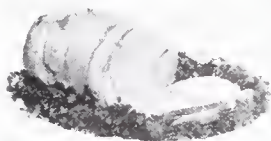
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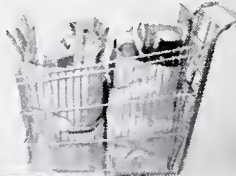
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March-April, 1969

HAWAII MEDICAL JOURNAL



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Program

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VOLUME 28 • NUMBER 4

**“coughing
is not a harmless
privilege”**

—Current Therapy 1967, ed. by Conn, H. F., P. 88—

**if cough
serves no useful
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Rx **Tussionex**[®]

(Resin complexes of Hydrocodone and Phenyltoloxamine)

**... it works
(usually
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hours*)**

TUSSIONEX SUSPENSION/TABLETS: Each teaspoonful (5 cc.) or tablet of TUSSIONEX contains 5 mg. hydrocodone (Warning: May be habit-forming) and 10 mg. phenyltoloxamine, both as cation exchange resin complexes of sulfonated polystyrene.

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***DOSAGE:** *Adults:* 1 teaspoonful (5 cc.) or tablet every 8-12 hours.
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TABLETS & GRANULES

■ to help restore and stabilize the intestinal flora

■ for fever blisters and canker sores of herpetic origin

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Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.^{1,2,3,4,5,6,7,8}

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

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Baltimore, Maryland 21201

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References:

(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

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VOLUME 28, NUMBER 4 • MARCH-APRIL, 1969 • \$6.00 A YEAR, \$1.00 A COPY

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A specific solution for tinea versicolor

Although tinea versicolor is not a serious disease it is chronic and recurrent and specific treatment is cosmetically important. "Of the wide variety of compounds recommended for the treatment of tinea versicolor, sodium thiosulphate still remains the standard."^{*} However, when sodium thiosulfate is administered alone it decomposes rapidly and produces an offensive odor. These disadvantages have been largely eliminated by the development of TINVER Lotion, which contains sodium thiosulfate and salicylic acid in MICEL A[®] base.[†]

TINVER—the likable lotion for tinea versicolor—is clinically effective, cosmetically acceptable, and easy to apply. It produces rapid, visible improvement without the objectionable features of oily pastes and odorous solutions. Patient acceptability encourages continued therapy without interruption. TINVER is

practical and economical for long-term therapy.

Indications: For topical use in the treatment of tinea versicolor.

Precautions: If signs of irritation or sensitivity develop, discontinue use. Do not use on or about the eyes.

Dosage and Administration: Thoroughly wash, rinse, and dry the affected area before applying medication. Apply a thin film of the lotion twice a day, or as directed. Although diagnostic evidence of the tinea versicolor may disappear in a few days, it is advisable to continue treatment for a much longer period. Clothing should be boiled to prevent reinfection.

Supply: 5 oz. polyethylene squeeze bottle.

^{*}McClarín, W. M., and Knox, J. M.: *Cutis* 3:619 (June) 1967.

[†]The MICEL A[®] base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.



Tinver[®] Lotion

Sodium thiosulfate USP 25%, salicylic acid USP 1%, isopropyl alcohol NF 10%, and propylene glycol USP, in a MICEL A base of menthol USP, disodium edetate, colloidal alumina, and purified water USP.



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References: 1. Merck & Co., Merck Chemical Division: Antacid Literature Survey, Rahway, New Jersey (MM3041, R-1286-K REV 463.) 2. Danhof, I.E., report on file. 3. Hoon, J.R.: Arch. Surg. 93:467 (Sept.) 1966

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aluminum and magnesium hydroxides *plus* simethicone



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New hormone ratio in low-dosage oral contraception

Norinyl[®]

1+80

(norethindrone 1 mg with mestranol 0.08 mg)

21&28

day regimens



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(norethindrone 1 mg with
mestranol 0.08 mg)



Oral contraceptives are different because women are different.

Just being secure in the knowledge that her oral contraceptive is effective is not enough. She also wants to be secure in the knowledge that her oral contraceptive is right for her.

Now you have a new choice in prescribing a low-dosage oral contraceptive.

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No matter how effective her oral contraceptive is... if she forgets, she loses the protection she's striving for.

Norinyl® 1+80 gives her the easiest regimen choice possible: either 21-day (3 weeks on, 1 week off) or 28-day continuous therapy (21 active tablets and 7 placebos). Both are simple and regular. Cycle days are replaced by weekdays — the way she lives her life.

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Norinyl®

1+80

(norethindrone 1 mg with
mestranol 0.08 mg)

21 & 28

day regimens

CONTRAINDICATIONS

1. Patients with thrombophlebitis, thromboembolic disorders, cerebral apoplexy, or with a past history of these conditions.
2. Patients with markedly impaired liver function.
3. Patients with known or suspected carcinoma of the breast.
4. Patients with known or suspected estrogen-dependent neoplasia.
5. Undiagnosed abnormal genital bleeding.

WARNINGS

1. The physician should be alert to the earliest manifestations of thrombotic disorders (thrombophlebitis, cerebrovascular disorders, pulmonary embolism, and retinal thrombosis). Should any of these occur or be suspected, the drug should be discontinued immediately.

Studies conducted in Great Britain and reported in April 1968 estimate there is a seven- to tenfold increase in mortality and morbidity due to thromboembolic diseases in women taking oral contraceptives. In these controlled retrospective studies, involving 36 reported deaths and 58 hospitalizations due to "idiopathic" thromboembolism, statistical evaluation indicated that the differences observed between users and nonusers were highly significant.

The conclusions reached in the studies are summarized in the table below:

COMPARISON OF MORTALITY AND HOSPITALIZATION RATES DUE TO THROMBOEMBOLIC DISEASE IN USERS AND NONUSERS OF ORAL CONTRACEPTIVES IN BRITAIN

Category	Mortality Rates		Hospitalization Rates (Morbidity)
	Ages 20-34	Ages 35-44	Ages 20-44
Users of Oral Contraceptives	1.5/100,000	3.9/100,000	47/100,000
Nonusers	0.2/100,000	0.5/100,000	5/100,000

No comparable studies are yet available in the United States. The British data, especially as they indicate the magnitude of the increased risk to the individual patient, cannot be directly applied to women in other countries in which the incidences of spontaneously occurring thromboembolic disease may be different.

2. Discontinue medication pending examination if there is sudden partial or complete loss of vision, or if there is a sudden onset of proptosis, diplopia or migraine. If examination reveals papilledema or retinal vascular lesions, medication should be withdrawn.

3. Since the safety of oral contraceptives in pregnancy has not been demonstrated, it is recommended that for any patient who has missed two consecutive periods, pregnancy should be ruled out before continuing the contraceptive regimen. If the patient has not adhered to the prescribed schedule, the possibility of pregnancy should be considered at the time of the first missed period.

4. A small fraction of the hormonal agents in oral contraceptives has been identified in the milk of mothers receiving these drugs. The long-range effect to the nursing infant cannot be determined at this time.

PRECAUTIONS

1. The pretreatment physical examination should include special reference to breast and pelvic organs, as well as a Papanicolaou smear.

2. Endocrine and possibly liver function tests may be affected by treatment with oral contraceptives. Therefore, if such tests are abnormal in a patient taking an oral contraceptive, it is recommended that they be repeated after the drug has been withdrawn for 2 months.

3. Under the influence of estrogen-progesterone preparations, preexisting uterine fibromyomata may increase in size.

4. Because these agents may cause some degree of fluid retention, conditions which might be influenced by this factor, such as epilepsy, migraine, asthma, cardiac or renal dysfunction, require careful observation.

5. In breakthrough bleeding, and in all cases of irregular bleeding per vaginam, nonfunctional causes should be borne in mind. In undiagnosed bleeding per vaginam, adequate diagnostic measures are indicated.

6. Patients with a history of psychic depression should be carefully observed and the drug discontinued if the depression recurs to a serious degree.

7. Any possible influence of prolonged oral contraceptive therapy on pituitary, ovarian, adrenal, hepatic or uterine function awaits further study.

8. A decrease in glucose tolerance has been observed in a significant percentage of patients on oral contraceptives. The mechanism of this decrease is obscure. For this reason, diabetic patients should be carefully observed while receiving oral contraceptive therapy.

9. Because of the effects of estrogens on epiphyseal closure, oral contraceptives should be used judiciously in young patients in whom bone growth is not complete.

10. The age of the patient constitutes no absolute limiting factor, although treatment with oral contraceptives may mask the onset of the climacteric.

11. The pathologist should be advised of oral contraceptive therapy when relevant specimens are submitted.

ADVERSE REACTIONS OBSERVED IN PATIENTS RECEIVING ORAL CONTRACEPTIVES

A statistically significant association has been demonstrated between use of

oral contraceptives and the following serious adverse reactions:

- Thrombophlebitis
- Pulmonary embolism

Although available evidence is suggestive of an association, such a relationship has been neither confirmed nor refuted for the following serious adverse reactions:

- Cerebrovascular accidents
- Neuro-ocular lesions, e.g., retinal thrombosis and optic neuritis

The following adverse reactions are known to occur in patients receiving oral contraceptives:

- Nausea
- Vomiting
- Gastrointestinal symptoms (such as abdominal cramps and bloating)
- Breakthrough bleeding
- Spotting
- Change in menstrual flow
- Amenorrhea during and after treatment
- Edema
- Chloasma or melasma
- Breast changes: tenderness, enlargement and secretion
- Change in weight (increase or decrease)
- Changes in cervical erosion and cervical secretions
- Suppression of lactation when given immediately postpartum
- Cholestatic jaundice
- Migraine
- Rash (allergic)
- Rise in blood pressure in susceptible individuals
- Mental depression

Although the following adverse reactions have been reported in users of oral contraceptives, an association has been neither confirmed nor refuted:

- Anovulation post-treatment
- Premenstrual-like syndrome
- Changes in libido
- Changes in appetite
- Cystitis-like syndrome
- Headache
- Nervousness
- Dizziness
- Fatigue
- Backache
- Hirsutism
- Loss of scalp hair
- Erythema multiforme
- Erythema nodosum
- Hemorrhagic eruption
- Itching

The following laboratory results may be altered by the use of oral contraceptives:

- Hepatic function: Increased sulfochromophthalein and other tests
- Coagulation tests: Increase in prothrombin Factors VII, VIII, IX, and X
- Thyroid function: Increase in PBI and butanol extractable protein-bound iodine, and decrease in T³ uptake values
- Metyrapone test
- Pregnanediol determination

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of

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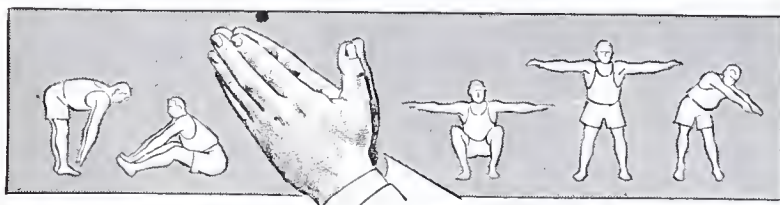


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OF WATERLOO BECAUSE
HE WAS TOO FAT!**

ACCORDING TO THE NEW YORK TIMES OF APRIL 13, 1890, THE DEFEAT OCCURRED BECAUSE HE FAILED TO CHECK HIS INTELLIGENCE INFORMATION. "IT WAS A MATTER OF MERE INDOLENCE AND THIS INDOLENCE WAS CAUSED BY FAT."

SOURCE: JAMA 186:65 (OCT. 5) 1963.



THE BOOK "PRAY YOUR WEIGHT AWAY" URGES READERS TO "ASK GOD TO HELP YOU LIKE EXERCISE" FOR 15 MINUTES A DAY.

SOURCE: REV. C.W. SHEDD: NEW YORK, LIPPINCOTT, 1958.



GALLSTONES HAVE BEEN FOUND IN 60% OF PATIENTS WHO WEIGH MORE THAN 300 POUNDS, 45% HAVE DIABETES, AND 15-TO-20% HAVE HIGH BLOOD PRESSURE.

SOURCE: DUNCAN, G.G.: SCIENCE NEWS LETTER, 83:403 (JUNE 29) 1963.



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*SOURCE: ARCHIVES OF GENERAL PSYCHIATRY 8:26 (JUNE 1963).

CONTROL FOOD AND MOOD ALL DAY LONG WITH A SINGLE MORNING DOS

One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety...helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting.

Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

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methamphetamine HCl 15 mg.,
phenobarbital 64.8 mg. (1 gr.)
(Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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but in rest from pain.”*

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**SHE HEARS MUSIC
THAT ISN'T THERE**

THEN THE SEIZURE BEGINS.

Some type of aura occurs in an estimated 50 per cent of epileptic patients.¹ This premonitory symptom of a seizure may provide a valuable clue to its epileptogenic focus.

"Focal types of convulsive disorders are now known to be the most common, and some authorities believe that all epilepsy has a focal ictus."² MYSOLINE (primidone) has been classified as a drug of choice in psychomotor and other focal seizures,³⁻⁵ and as an "excellent" agent for the control of grand mal.⁶

In fact, MYSOLINE has been found particularly effective in intractable cases of grand mal^{1,5,7} and psychomotor epilepsy,^{1,4} where other drugs, such as phenobarbital and diphenylhydantoin, had failed.

An "effective drug which has now stood the test of time,"⁴ MYSOLINE may be used alone or, if needed, in combination with other anticonvulsants to advantage.

Early side effects of MYSOLINE are generally more unpleasant than dangerous, and tend to disappear as treatment is continued.⁷ Some patients may exhibit excessive drowsiness which may be largely avoided by starting with a very low dose of MYSOLINE given at bedtime.⁶ The low initial dose is gradually increased at weekly intervals until the effective anticonvulsant dosage is reached or tolerance is evident. (MYSOLINE is available in two potencies—in 50 mg. and in 0.25 Gm. (250 mg.) scored tablets.)

Service Aids: To help promote a better understanding of epilepsy and improve the cooperation of patients (young or adult), their relatives and friends, Ayerst Laboratories has prepared a series of service aids, including specially prepared and illustrated booklets. All of these are available in quantity upon request.

Indications: Control of grand mal and psychomotor attacks.

Precautions: A dosage exceeding 2 Gm. daily is not recommended. As with any drug used over prolonged periods of time, it is recommended that routine laboratory studies be made at regular intervals.

Side Effects: The most frequently occurring early side effects are ataxia and vertigo. These tend to disappear with continued therapy, or with reduction of initial dosage. On rare occasion, persistent or severe side effects may necessitate withdrawal of the drug. Occasionally, the following have been reported: nausea, anorexia, vomiting, fatigue, hyperirritability, emotional disturbance, diplopia, nystagmus, drowsiness, and morbilliform skin eruptions. Megaloblastic anemia may occur as a rare idiosyncrasy to MYSOLINE (primidone). The anemia responds to folic acid, 15 mg. daily, without the necessity of discontinuing therapy.

References: 1. Lennox, W. G., in Cecil, R. L., and Loeb, R. F.: A Textbook of Medicine, ed. 10. Philadelphia, Saunders, 1959, pp. 1426-1434. 2. Aird, R. B.: Mod. Med. 35:30 (Aug. 14) 1967. 3. Forster, F. M.: Modern Therapy in Neurology, St. Louis, Mosby, 1957, p. 402. 4. Merlis, J. K.: Maryland Med. J. 12:553 (Nov.) 1963. 5. Millichap, J. G.: Postgrad. Med. 37:22 (Jan.) 1965. 6. Livingston, S.: Drug Therapy for Epilepsy. Anticonvulsant Drugs: Usage, Metabolism and Untoward Reactions (Prevention, Detection and Management), Springfield, Ill., Thomas, 1966, pp. 21-28. 7. Toman, J. E. P., in Goodman, L. S., and Gilman, A.: The Pharmacological Basis of Therapeutics, ed. 3, New York, Macmillan, 1965, p. 226.

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FOR EFFECTIVE SEIZURE CONTROL



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**Typically, after 10 days there's no pain.
The patient is comfortable.
The urinary infection is gone.**

But for how long?

**The high rates of recurrence of
bacteriuria suggest the need for long-term
suppressive therapy.**

Long-term therapy in chronic urinary tract infections¹

A recent review of treatment of urinary infections indicates the value of long-term (1 year) use of methenamine mandelate routinely in chronic, recurrent infections after the urine has been sterilized. It further notes that it is relatively nontoxic and inexpensive, and points out that methenamine mandelate makes urine a poor culture medium and often eradicates resistant pathogens.

Careful management and control of urinary acidification is stressed. Urine pH should be maintained and dietary and/or supplemental acidification adjusted as required. This program controlled many previously intractable urinary infections.

Long-term therapy in a continuing study of adult males²

A continuing study in seven U.S. Public Health Service hospitals demonstrates the efficacy of Mandelamine in controlling recurrent bacteriuria in adult males. Initial broad-spectrum antibiotic therapy eradicated bacteriuria in 88 percent of 122 patients. Then each of these patients was placed randomly in one of four treatment groups. After 13 months, the rate of recurrence of bacteriuria in these males was found to be lower with all antibacterials, as compared with placebo, and the rate was lowest with Mandelamine.

1. Hosp. Med. 4:73 (May) 1968.
2. Scientific Exhibit — "The Control of Recurrent Bacteriuria," U.S.P.H.S. Cooperative Study, Shown at A.M.A. Clinical Convention, Houston, Texas, November 26-29, 1967.
3. Am. J. Dis. Child. 105:560, 1963.

Indications: Mandelamine (methenamine mandelate) is indicated for the suppression or elimination of bacteriuria associated with pyelonephritis, cystitis and other urinary tract infections; also for infected residual urine sometimes accompanying neurologic diseases. When used as recommended, Mandelamine (methenamine mandelate) is particularly suitable for long-term therapy because of its safety and because resistance to the nonspecific bactericidal action of formaldehyde does not develop. Pathogens resistant to other antibacterial agents may respond to Mandelamine (methenamine mandelate) because of the nonspecific bactericidal effect of formaldehyde formed in an acid urine.

Contraindication: Contraindicated in renal insufficiency.

Dosage and Management: Adults — 1 Gm. *q.i.d.* Since an acid urine is essential for antibacterial activity with maximum efficacy occurring at pH 5.5 or below, restriction of alkalinizing foods and medication is desirable. If testing of urine pH reveals the need, supplemental acidification should be given. (See Precautions.)

Long-term therapy in children³

A series of twenty young girls (14 months to 12½ years old) presented a history of 160 documented urinary tract infections, 46 requiring hospitalization, while receiving intermittent antibiotic or sulfonamide therapy. The rate of recurrence was strikingly reduced following the institution of a regimen of prophylactic therapy utilizing Mandelamine (methenamine mandelate) and a urinary acidifying agent. During the treatment period (an average of 2.25 years) only five patients failed to respond.

A logical choice

There has been increasing interest in the use of long-term suppressive therapy, although the benefits are not yet fully established. However, when the decision is made to utilize long-term suppressive therapy, Mandelamine is a logical choice. Particularly when utilized immediately after antibiotic therapy, Mandelamine, in conjunction with a urinary acidifier, if necessary, is a highly useful agent in preventing recurrences of bacteriuria. Through its local action in the urine, Mandelamine exerts its antibacterial effect against a wide range of gram-negative and gram-positive pathogens. Major toxicity is almost never a cause for discontinuing therapy, although mild reactions — skin rash, dysuria, gastrointestinal upset — may occur. Cost to the patient is relatively low — an important consideration when initiating long-term therapy.

	Dosage Form	Dosage
1 Gm.	Mandelamine Tablets (methenamine mandelate)	Adults: 1 tablet <i>q.i.d.</i>
	Mandelamine Suspension Forte (methenamine mandelate) 500 mg./tsp.	Children 6-12: 1 teaspoonful or 1 tablet <i>q.i.d.</i>
½ Gm.	Mandelamine ½ Gm. Tablets (methenamine mandelate)	Adults: 2 teaspoonfuls or 2 tablets <i>q.i.d.</i>
	Mandelamine Suspension (methenamine mandelate) 250 mg./tsp.	Children 5 or under: 1 teaspoonful or 1 tablet per 30 lb. body weight <i>q.i.d.</i>
¼ Gm.	Mandelamine ¼ Gm. Tablets (methenamine mandelate)	

Precautions: Dysuria may occur (usually at higher than recommended dosage). This can be controlled by reducing the dosage and/or acidification. When urine acidification is contraindicated or unattainable (as with some urea-splitting bacteria), the drug is not recommended.

Adverse Reactions: An occasional patient may experience gastrointestinal disturbance or a generalized skin rash.

Full information is available on request.

WARNER-CHILCOTT
Morris Plains, New Jersey



MANDELAMINE[®]

(methenamine mandelate)

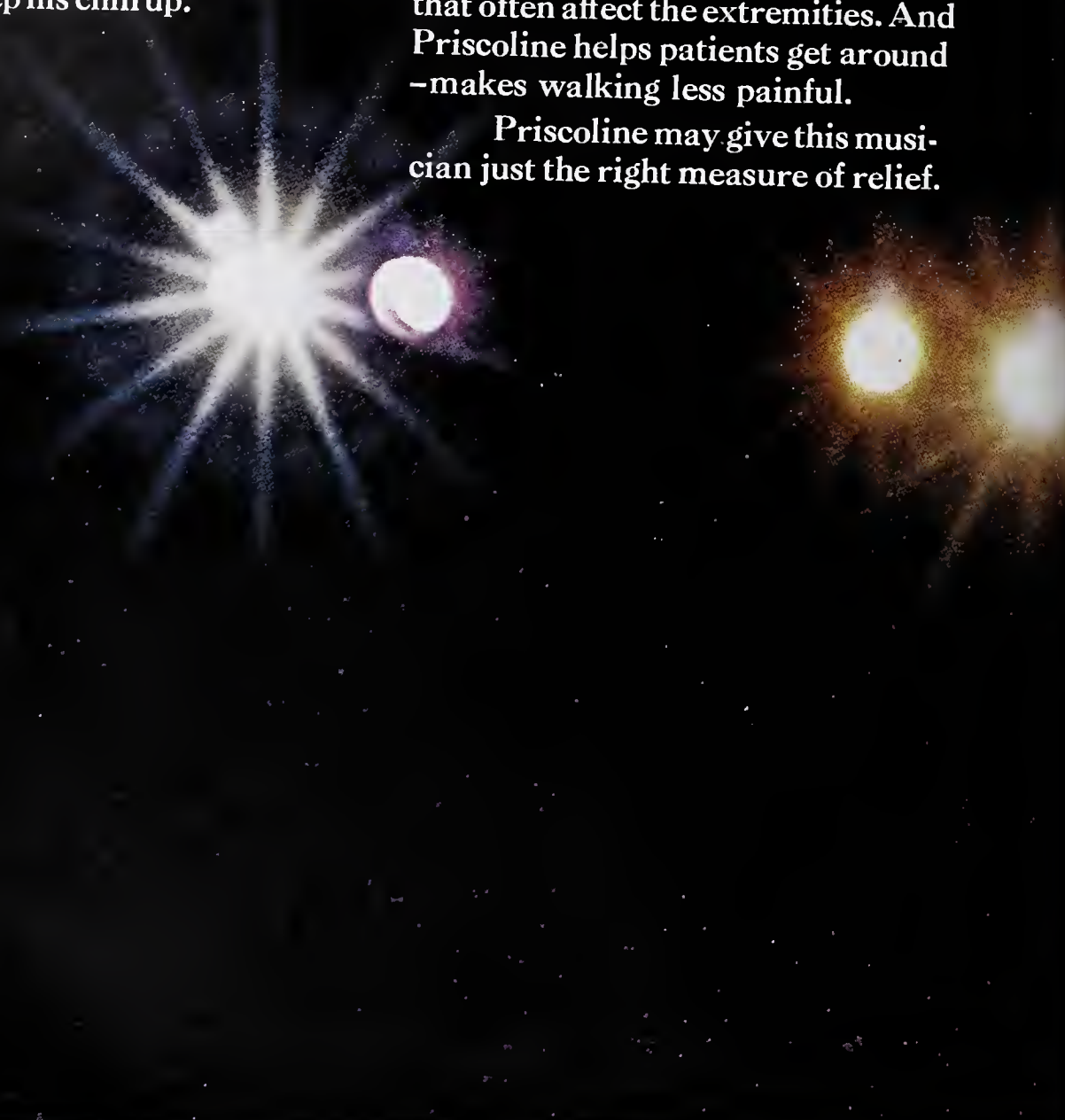
Logical long-term urinary antibacterial

Priscoline[®] could help (tolazoline)

His moment has arrived, but there's one false note—peripheral vascular disease. Mittens may warm his hands, but that's cold comfort. It's not surprising he finds it hard to keep his chin up.

Priscoline can give patients the hand they need. It dilates peripheral blood vessels, increases blood flow to hands and feet. Frequently relieves numbness and chill that often affect the extremities. And Priscoline helps patients get around—makes walking less painful.

Priscoline may give this musician just the right measure of relief.



Priscoline[®] hydrochloride
(tolazoline hydrochloride)

Oral Peripheral Vasodilator

INDICATIONS

Spastic peripheral vascular disorders.

PRECAUTIONS

Priscoline stimulates gastric activity and increases hydrochloric acid content of the stomach; use cautiously in patients with gastritis or peptic ulcer or in those with suspected peptic ulcer. Give cautiously, if at all, to patients with known or suspected coronary artery disease.

ADVERSE REACTIONS

Occasional: nausea, epigastric discomfort, tachycardia, flushing, slight rise or fall in blood pressure, increased pilomotor activity with tingling or chilliness. Rare: vomiting, diarrhea. Symptoms are generally mild and frequently disappear with continued therapy, regardless of dosage.

DOSAGE

Careful individualization of dosage is required.

Tablets: Usually 25 mg 4 to 6 times daily is sufficient. If necessary, dosage may be increased gradually up to 50 mg 6 times daily.

Lontabs: Generally, 1 Lontab every 12 hours will achieve the same effect as one 25-mg regular tablet every 4 hours (6 times a day). Thus continuous action throughout the night is achieved without the need for arising to take additional medication.



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Tablets, 25 mg (white, scored);
bottles of 100 and 1000.

Lontabs, 80 mg (bright yellow);
bottles of 100.

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consult complete literature before
prescribing.

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It's almost as if you were there to give an injection of penicillin



V-Cillin K[®], Pediatric dependable oral penicillin therapy

Potassium Phenoxymethyl Penicillin

Description: V-Cillin K, the potassium salt of V-Cillin[®] (phenoxymethyl penicillin, Lilly), combines acid stability with immediate solubility and rapid absorption. Higher, more rapid serum levels are obtained than with equal oral doses of penicillin G.

Indications: Streptococcus, pneumococcus, and gonococcus infections; infections caused by sensitive strains of staphylococci; prophylaxis of streptococcus infections in patients with a history of rheumatic fever; and prevention of bacterial endocarditis after tonsillectomy and tooth extraction in patients with a history of rheumatic fever or congenital heart disease.

Contraindication: Penicillin hypersensitivity.

Warnings: In rare instances, penicillin may cause acute anaphylaxis which may prove fatal unless promptly controlled. This type of reaction appears more frequently in patients with a history of sensitivity reactions to penicillin or with bronchial asthma or other allergies. Resuscitative drugs should be readily available. These include epinephrine and pressor drugs (as well as oxygen for inhalation) for immediate allergic manifestations and antihistamines and corticosteroids for delayed effects.

Precautions: Use cautiously, if at all, in a patient with a strongly positive history of allergy.

In prolonged therapy with penicillin, and particularly with high parenteral dosage schedules, frequent evaluation of the renal and hematopoietic systems is recommended.

In suspected staphylococcus infections, proper laboratory studies (including sensitivity tests) should be performed.

The use of penicillin may be associated with the overgrowth of penicillin-insensitive organisms. In such cases, discontinue administration and take appropriate measures.

Adverse Reactions: Although serious allergic reactions are much less common with oral penicillin than with intramuscular forms, manifestations of penicillin allergy may occur.

Penicillin is a substance of low toxicity, but it possesses a significant index of sensitization. The following hypersensitivity reactions have been reported: skin rashes ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; and reactions resembling serum sickness, including chills, fever, edema, arthralgia, and prostration. Severe and often fatal anaphylaxis has occurred (see Warnings). Hemolytic anemia, leukopenia, thrombocytopenia, and nephropathy are rarely observed side-effects and are usually associated with high parenteral dosage.

Administration and Dosage: Usual dosage range, 125 mg. (200,000 units) three times a day to 500 mg. (800,000 units) every four hours. For infants, 50 mg. per Kg. per day divided into three doses.

See package literature for detailed dosage instructions for prophylaxis of streptococcus infections, surgery, gonorrhea, and severe infections.

How Supplied: Tablets V-Cillin K[®] (Potassium Phenoxymethyl Penicillin Tablets, U.S.P.), 125 mg. (200,000 units), 250 mg. (400,000 units), and 500 mg. (800,000 units).

V-Cillin K[®] (potassium phenoxymethyl penicillin, Lilly), Pediatric, for Oral Solution, 125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc. of solution (approximately one teaspoonful).

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Additional information available to physicians upon request.

Eli Lilly and Company, Indianapolis, Indiana 46206



There was no rabies on Oahu in 1967!

Epidemiologic evidence provides independent refutation.

Suspected Rabies in Retrospect, Oahu, Hawaii

K. L. GOULD, M.D.,* J. M. GOOCH, D.V.M., M.P.H.†
A. ODA, B.S.,‡ I. D. HIRSCHY, M.D., M.P.H.,§ Honolulu

● *Rabies was reported on the island of Oahu for the first time in October, 1967. The reports were not confirmed, and it is now evident that the laboratory diagnoses were wrong. Even if they had been confirmed, however, the sudden appearance of such a large number of cases in so short a time, and the equally abrupt subsidence of the "epidemic," is wholly inconsistent with a disease transmitted by direct contact and having an incubation period of four to six weeks. No rabies epizootic occurred here in 1967; Hawaii was, and still is, a rabies-free area.*

NO RABIES had been identified in Hawaii prior to October, 1967. However, there had recently been an epizootic of rabies in Guam, previously a rabies-free area. Although an antirabies quarantine program has been in effect in Hawaii for many years, the risk of introducing rabies virus into this State from Guam or other areas is real. In addition, Hawaii has a large population of mongooses, animals which maintain a reservoir of

rabies in Puerto Rico and South Africa. If rabies became endemic in the mongoose population, eradication would be costly and difficult, if not impossible. This species could become a potential source for human cases in Hawaii, particularly among agricultural workers.

On Oahu on October 3, 1967, a rat brain was identified as rabid by fluorescent antibody technique and Seller's staining at a laboratory in Hawaii. Subsequently, more animals from Oahu were identified as rabid and the possibility of a rabies epizootic on this island became apparent.

The entire State of Hawaii was alerted to cope with the rabies problem. On October 4 military and civilian personnel held an emergency meeting to coordinate control efforts. On October 9, at a meeting of the State cabinet, administrative staff and budget were organized to deal with the problem. This organization, the Joint Rabies Control Project, coordinated activities of various State agencies. Programs for trapping animals, for reporting bites, and for quarantine follow-up on biting animals were undertaken. Antirabies therapy of bite cases and prophylactic vaccinations of high-risk groups were started. Thirty-six hundred doses of duck embryo vaccine were eventually distributed for treatment of bite cases and a total of ninety-four persons were eventually reported as treated with antirabies therapy. Many

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§ Executive Officer, Communicable Disease Division, Hawaii Health Department.

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animals were quarantined for observation or destroyed as unwanted pets at the request of their owners. An estimated \$70,000 of State government funds were expended on this problem through the Joint Rabies Control Project. In short, the State responded with remarkably rapidity to the threat of rabies.

However, throughout these activities there were major questions about the laboratory diagnosis and epidemiology in the suspected epizootic. Physicians were cautioned against unnecessary vaccination of bitten persons in circulars from the Communicable Disease Division of the Hawaii Health Department on October 24, 20 days after the first alarm, and again on November 17, 1967. In December the Director of Health stated "—it is apparent that Hawaii does not have a rabies epizootic. Whether the disease has been introduced into the islands at all is doubtful."²

Laboratory diagnostic work for rabies was not performed in the Hawaii Health Department during the suspected epizootic. It is not appropriate in this report to review the laboratory diagnostic procedures utilized, since these have been discussed elsewhere.³ The findings, however, will be presented for review from an epidemiologic point of view in order to provide perspective and an approach completely independent of the problems of laboratory diagnosis at that time.

METHODS

Epidemiology of the suspected outbreak. A release of the Joint Rabies Control Project dated December 11, 1967, supplied a final complete listing of the animal brains tested, the species, the date and geographic area of collection, and the results of testing by Seller's staining or fluorescent antibody technique at civilian laboratories in Hawaii. During the suspected epizootic a listing of animals reported as positive at military laboratories was provided by staff of the Joint Rabies Control Project. However, a listing of the total number of animals examined at military facilities was not available. A "positive animal" is defined as an animal reported to the Joint Rabies Control Project as rabid by one of the two Hawaii laboratories performing diagnostic work for rabies during the suspected epizootic. The term does not imply that rabies virus was identified or confirmed either by reference laboratories or by the Hawaii Health Department Laboratory.

Animal survey. Because of remaining questions, the Hawaii Health Department undertook a survey for rabies in Hawaii in cooperation with the National Communicable Disease Center (NSDC)

during February, March, and April, 1968. Detection of a very low incidence in the animal population would require an unrealistically large sample in order to be statistically significant. A sample was obtained large enough so that it could reasonably be expected to disclose the presence or absence of rabies virus in selected susceptible elements of the State's animal population and still be within the resources of the State. The NCDC provided a technician, experienced in laboratory diagnosis of rabies, who worked with laboratory personnel of the Hawaii Health Department.

Survey animals of various species—dog, cat, mongoose, rat, and mouse—were collected from various parts of Oahu, Hawaii, Kauai, and Maui. An attempt was made to select animals who showed abnormal behavior or symptoms of encephalitis. Brains of survey animals were screened by standard fluorescent antibody technique and Seller's staining, with confirmation of all results by laboratory personnel of the NCDC. Known positive and negative slides were prepared as controls throughout the survey study. Brains showing any fluorescence or any type of inclusion bodies by Seller's staining were inoculated into suckling and six-week-old mice, with observation for twenty-one days.

RESULTS AND DISCUSSION

Epidemiology of the suspected outbreak. In this section on epidemiology a "positive" animal, as defined under methods, is an animal which was reported as rabid to the Joint Rabies Control Project. It should be emphasized that this term does not imply the demonstration of rabies virus with confirmation by reference laboratories. A positive rate refers to the number of positive heads so defined, divided by the total number of animals examined.

It was reported that between November, 1966, and October 3, 1967, approximately three to four mongooses, one dog, and one cat per month from Oahu had been examined for rabies and were negative.⁴ On October 3, a suspected index animal case was identified. This was a rat which bit a child. Subsequently, 55 heads were identified as positive. According to reports sent to the Hawaii Health Department, 16 of these reportedly positive brains were sent to the NCDC reference laboratory, where all were found negative for "wild" or "street" rabies virus.

By analyzing all the reportedly positive brains, the epidemiology of the suspected epizootic can be described for comparison with generally accepted concepts of rabies. This approach is utilized in the following discussion.

TABLE 1.—*Animals of all species reportedly positive for rabies during the suspected epizootic, Oct. 3 to Nov. 29, 1967, Oahu, Hawaii**.

SOURCE	TESTED	POSITIVE	% POSITIVE
Civilian lab. before Oct. 3	50-60	0	0
Civilian lab. after Oct. 3	156	27	17.0
Military lab. after Oct. 3	Unknown	28	Unknown
TOTAL	—	55	—

* Data provided by staff of the Joint Rabies Control Project.

TABLE 2.—*Animals tested for rabies in four states, all species.*

STATE	TESTED	POSITIVE	% POSITIVE	OVER YEARS
New Jersey	1756	7	0.4	5
Georgia	28,645	5212	18.2	20
California	5855	550	9.4	2
Florida	21,150	565	2.7	8
TOTAL	57,406	6334	11.0	

From Proceedings of National Rabies Symposium, 1966, National Communicable Disease Center.

TABLE 3.—*Animals reportedly positive for rabies during three equal time periods of the suspected epizootic, Oct. 3 to Nov. 29, 1967, Oahu, Hawaii.*

PERIOD ¹	NUMBER TESTED ²	POSITIVE	% POSITIVE
Before Oct. 3	50-60	0	0
First period	131	26	19.9
Middle period	15	1	6.7
Final period	10	0	0
TOTAL (Oct. 3-Nov. 29)	156	27	17.0

¹ Each period is 19 days.
² Data provided by staff of the Joint Rabies Control Project.

Figure 1 shows the epidemic curve of animal brains called positive. The salient feature of this curve is the sharp rise within a period of a week

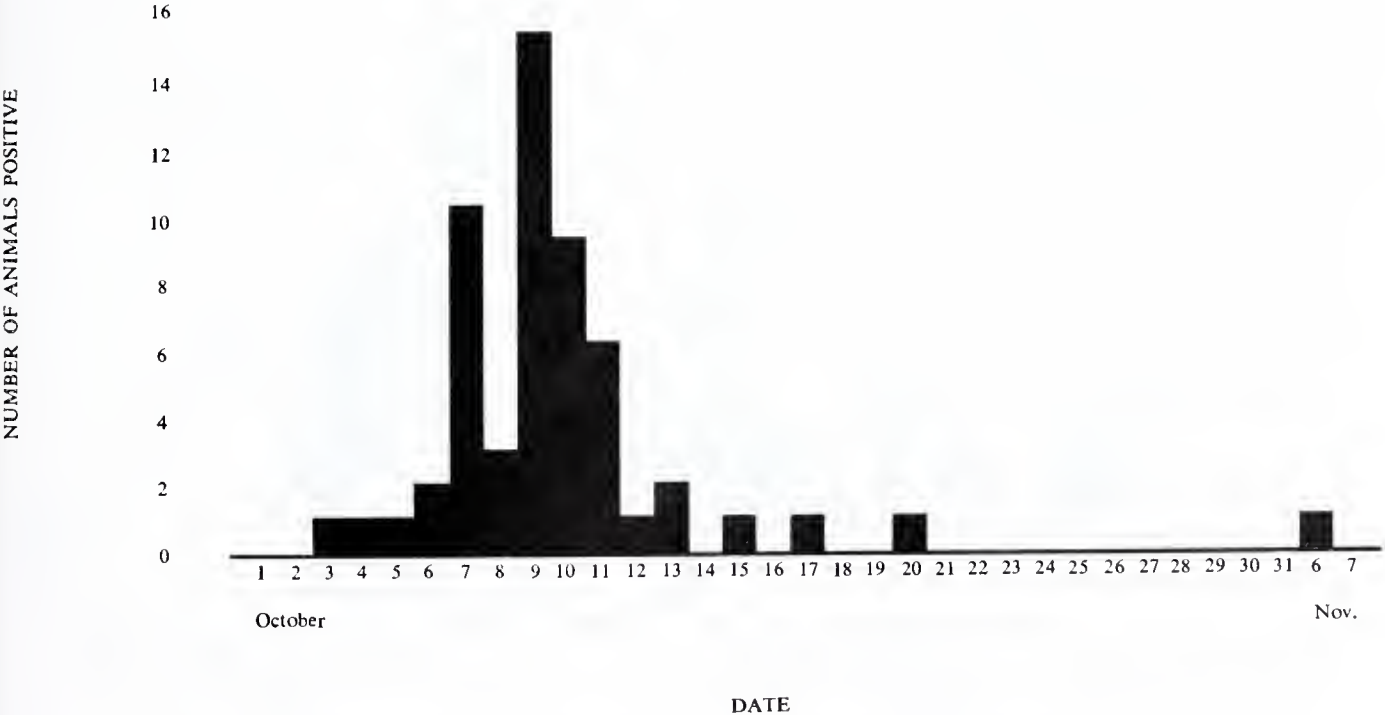


FIG. 1.—*Daily number of animals identified as positive on Oahu, Hawaii, Oct. 3 to Nov. 29, 1967.*

if adjustment is made for “more looking.” If the period October 4 to November 29 is divided into three equal parts, it can be seen that the positive rates change remarkably quickly, from 0 per cent to 19.9 per cent in 19 days, falling to 6.7 per cent and 0 per cent in the subsequent two 19-day periods. Since rabies is spread by direct contact (biting) with an incubation period of four to six weeks, it is difficult to understand how a suspected rabies epizootic could build up to such remarkably high positive rates in less than three weeks. It is even more difficult to understand how a suspected rabies epizootic could taper off to a low or zero positive rate in less than three weeks if the animal population was indeed heavily infected.

Table 4 shows the positive rate by species on Oahu. These positive rates range from 6.5 per cent for the mongoose to 22.7 per cent for rodents. Although the positive rate for rodents is larger than that of the carnivores, the difference between these two figures is probably not significant, and the percentages indicate that there was little species specificity on Oahu. For comparison purposes, this table includes figures from four mainland states. There is very marked species specificity

TABLE 4.—*Animals tested for rabies on Oahu, Hawaii, by species, 1967.*

SPECIES	POSITIVE	TESTED	% POS.	MAINLAND % POSITIVE	
Dog	2	11	18.2	7.5	USA ¹
Mongoose	2	31	6.5	6.2	Puerto Rico ¹
Rodents	17	75	22.7	0.023	Four States ²
Cat	5	35	14.3		Unknown
Pig	1	4	25.0		Unknown
TOTAL	27	156	17.0	11.0	Four States ²

¹ Estimates based on calculations from Proceedings of National Rabies Symposium 1966 and the Annual Rabies Summary 1966, National Communicable Disease Center.
² Calculated from data of the Proceedings of National Rabies Symposium, 1966.

of natural infection by rabies virus on the mainland, where only 0.023 per cent of all rodents examined were found to be rabid. The positive rate reported for all rodents on Oahu is 1,000 times the positive rate seen in these mainland states. Although not shown in the table, the positive rate for rats alone, on Oahu, is approximately 10,000 times that seen in these states. On Oahu there is little species specificity among positive animals, whereas on the mainland, natural infection by rabies virus shows marked species specificity.



FIG. 2.—*Geographic distribution of animals reportedly positive for rabies on Oahu, Hawaii, 1967.*

Figure 2 shows the geographic distribution of reportedly positive animals on Oahu. The salient feature is the wide geographic spread over an area of 300 to 400 square miles. It is unlikely that rabies virus could have become so extensive over this area with such high positive rates within 19 days, or at least without one animal appearing rabid prior to October 3, 1967.

Reports of humans bitten by animals were collected during the suspected epizootic. Figure 3 shows the epidemic curve of humans reported as bitten. It is superimposed on the epidemic curve of positive animals. Three hundred and seventy-five civilian and military persons were reported as bitten between October 4 and October 24. This gives a minimum rate at which humans were bitten, of 84 per 100,000 per month. For comparison, a study by Parrish on the epidemiology of dog bites⁶ showed a dog-bite rate of 70 per 100,000 per month in a mainland city. From reports sent to the Hawaii Health Department from the states of Maryland and Indiana for 1967, the calculated bite rates were 41 and 19 per 100,000 per month for all species. It is apparent from these figures that the bite rate on Oahu was within the range of those found elsewhere. The important

TABLE 5.—Species distribution of biting animals, Oct. 3 to Nov. 29, 1967, Oahu, Hawaii.*

SPECIES	PERSONS BITTEN	% OF TOTAL
Dog	104	53.0
Cat	62	31.6
Rat	8	4.1
Rabbit	5	2.6
Mouse	5	2.6
Mongoose	3	1.5
Guinea Pig	3	1.5
Pig	2	1.0
Monkey	1	0.5
Unknown	3	1.5
TOTAL	196	100.0

* Data from civilian reports to the Hawaii Health Department.

feature of this curve is the abrupt rise and fall of bites reported, which exactly parallels the rise and fall of positive animals.

The significance of this feature is seen from Table 5 showing the species distribution of animals from civilian bite reports. The most common biting species are the dog and cat. This species distribution is similar to that found in mainland states. However, it does not parallel the species distribution of positive animals on Oahu. The increase in bites cannot be explained by an increase in suspected rabid animals, but can be explained

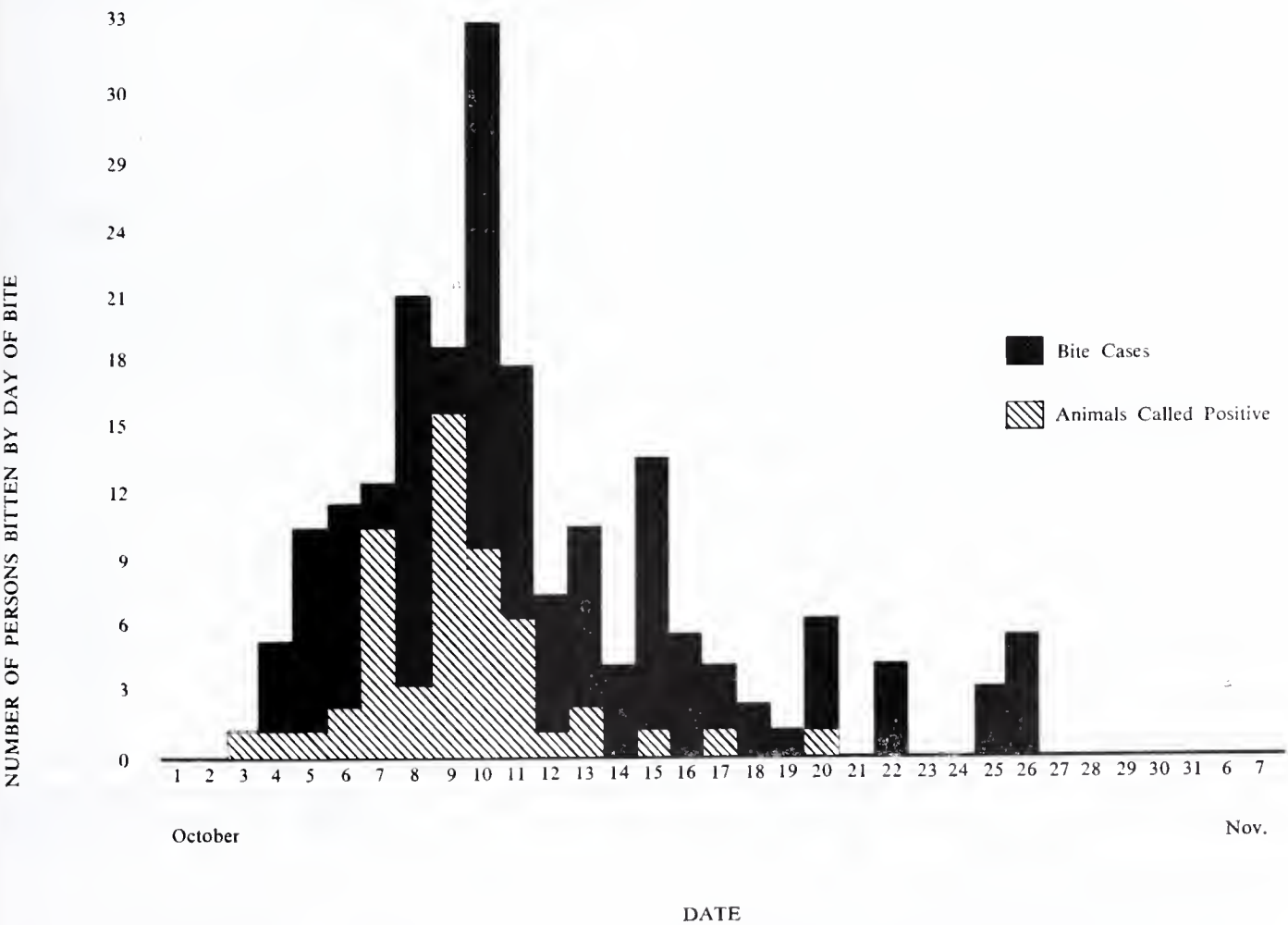


FIG. 3.—Civilians reported bitten, Oahu, Hawaii, October 3 to November 29, 1967.

TABLE 6.—Number of survey animals tested and negative for rabies* by species and island, February through April, 1968, Hawaii.

SPECIES	OAHU	HAWAII	KAUAI	MAUI	TOTAL
Rat	109	5	20	11	145
Mongoose	46	20	0	22	88
Mouse	4	1	1	0	6
Dog	32	10	11	6	59
Cat	17	0	0	2	19
TOTAL	208	36	32	41	317

* At the Hawaii Health Department.

by increased awareness of the need for reporting during the period of intensive publicity.

The following points summarize the epidemiologic features of the epizootic suspected on Oahu: (1) high positive rates within 19 days, followed by low and finally zero positive rates at 19-day intervals; (2) little or no species specificity of positive animals; (3) wide geographic distribution within 19 days; (4) increased reporting of bite cases.

Animal survey: During the period February 1 to April 29, 1968, 317 animals were examined at the Hawaii Health Department by fluorescent antibody technique and Seller's staining. Twenty-nine animals out of the 317 showed some clinical or laboratory abnormality subsequently found to be unrelated to rabies. Twenty-five of these twenty-nine had nonspecific inclusion bodies or nonspecific fluorescence, or had bitten humans, and were negative on mouse inoculation. Seven of the twenty-nine had symptoms of central nervous system disease and were negative by Seller's staining and fluorescent antibody technique. The species and island distribution of survey animals is seen in Table 6. The various clinical and laboratory findings in the twenty-nine animals are shown in Table 7. No survey animal was positive for rabies by any technique.

CONCLUSION

Epidemiologically there are major differences

between the suspected epizootic and the generally accepted concepts of rabies. The appearance of relatively high positive rates and the wide geographic distribution on Oahu in a period of 19 days is inconsistent with the concept of natural rabies transmission by direct contact (biting) with an incubation period of four to six weeks. The disappearance of positive animals within this short period is even more inconsistent with rabies, for the same reasons. The absence of species specificity in positive animals on Oahu is inconsistent with the species specificity observed elsewhere.

On the basis of these epidemiologic data, independent of problems in laboratory diagnosis, the authors believe that no rabies epizootic occurred during the fall of 1967 in Hawaii. This conclusion is further supported by a subsequent survey which failed to demonstrate rabies virus in any animal tested. Within acceptable limits of the epidemiologic and survey approach it is reasonable to conclude that Hawaii was, and remains, a rabies-free area.

ACKNOWLEDGMENTS

The authors are indebted to personnel of the Department of Agriculture, Department of Health, United States Army and the National Communicable Disease Center for their consultation, cooperation, and patience in obtaining data for this report.

REFERENCES

1. Tierkel, E. S., Arbona, G., Rivera, A., and de Juan, A.: Mongoose rabies in Puerto Rico, Public Health Rep. 67:274-278 (Mar. 3) 1952.
2. Quisenberry, W. B.: No room for complacency, Hawaii Health Messenger (Nov.-Dec.) 1967.
3. Press Release No. 2-68, Information Office, United States Army, Pacific, Fort Shafter, Hawaii, January 16, 1968. Epidemic Aid Report on Hawaiian Rabies, October 23, 1967, National Communicable Disease Center, Atlanta, Georgia.
4. Personal communication in October, 1967, by the State Veterinary Pathologist, Hawaii Department of Agriculture.
5. Proceedings of National Rabies Symposium, 1966, Department of Health, Education and Welfare, National Communicable Disease Center, Atlanta, Georgia.
6. Parrish, H. M., Clack, F. B., Brobst, D., Mock, J. F.: Epidemiology of dog bites, Public Health Rep. 74:891-903 (Oct. 10) 1959.

TABLE 7.—Clinical and laboratory findings in 317 survey animals*, February through April, 1968, Hawaii.

NUMBER OF ANIMALS BY SPECIES	SYMPTOMS OF CENTRAL NERVOUS SYSTEM DISEASE	HUMAN EXPOSURE	NON-SPECIFIC FLUORESCENCE	NON-SPECIFIC INCLUSIONS	MOUSE INOCULATION
3 cats, 4 mongoose, 12 rats	none	none	none	yes	negative
2 rats, 1 mouse	none	yes	none	none	negative
2 dogs, 1 mongoose, 1 rat	yes	none	none	none	not done
1 dog	yes	none	none	yes	negative
1 dog	yes	none	yes	none	negative
1 cat	yes	yes	none	yes	negative
Total, By Species	4 dogs, 1 cat, 1 mongoose, 1 rat	1 cat, 2 rats, 1 mouse	1 dog	1 dog, 4 cats, 4 mongooses, 12 rats	2 dogs, 4 cats, 4 mongooses, 14 rats, 1 mouse
TOTAL, ALL SPECIES (29)	7	4	1	21	25

* At the Hawaii Health Department.

Insecticides Household Use and Respiratory Impairment

BETSY P. WEINER, M.D., and ROBERT M. WORTH, M.D., Ph.D., *Honolulu*

● *Chronic exposure to household insecticides and a history of asthma, chronic bronchitis, and sinusitis are linked in data from a random sample of people on Oahu, Hawaii. A blind follow-up study of a subsample of this population two years later reveals significant correlation between frequent use of insecticides and respiratory impairment as measured by spirometry. Excluding cigarette smokers strengthens this comparison. Exposed persons also have significantly more respiratory symptoms.*

TO LOOK FOR possible harmful effects associated with frequent home use of pesticides, in 1965 we asked the Hawaii State Department of Health to include a pesticide questionnaire in their ongoing health interview survey. Demographic, health, and pesticide data from 1567 households visited by this survey cover a random sample of about 1 per cent of the population of the island of Oahu (City and County of Honolulu). The evidence from these 1965 data shows a correlation between frequent insecticide use in the home and increased prevalence of asthma, chronic bronchitis, and sinus trouble. Apart from respiratory disorders, we could find no suggestive statistical evidence linking any other chronic condition¹ and insecticide use.

METHOD

Insecticide use and asthma are both common in Hawaii. One-fourth of our population uses insecticides daily (5.5%) or weekly (19.0%). Three-fourths report less frequent use, monthly to yearly (68.7%) or not at all (6.8%).

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From the School of Public Health and Pacific Biomedical Research Center, University of Hawaii.

Selecting the two extremes, daily use and no use, as being at greatest risk and least risk to possible adverse effects from insecticides, we concentrated on these two groups. The daily-use group consists of 376 persons, and there are 328 non-users. The former have a slightly larger proportion of children under 15 years of age. All ethnic groups in Hawaii are equally represented in both groups. Income and educational levels, occupation, and place of residence are similar in the two groups.

Asthma, chronic bronchitis, or both, are reported for 99 of 376 persons in the daily use group as compared with only 61 of 328 persons reporting no use ($p < .05$). Repeated attacks of sinus trouble are also reported significantly more frequently in the daily use group ($p < .01$).

To test the hypothesis that frequent use of insecticides is associated with increased frequency of respiratory difficulties, a blind follow-up study two years later of the same population gives us a more complete assessment for comparison. All people still living at the same address are included. Of these, 350 persons, or 93% of those who had not moved, were reached in their homes in the summer of 1967. An additional 30 people born or moved into these homes in the interim are included. At this visit an extensive history was obtained for each individual, as well as environmental observations of vegetation, animals, and mold odor for each household. Respiratory symptoms, past and present medical conditions, smoking habits, and occupational and all household exposures were tabulated. Respiratory function tested by Vitalor spirometer provided a permanent tracing for comparison with normative standards. Auscultation of the lungs was also done. To avoid bias, questions on insecticide use came at the end of each visit.

TABLE 1.—*Ventilatory Function and Insecticide Use at Home in 142 Adults.*

NUMBER OF PERSONS		NUMBER OF PERSONS BY CLASS			
VENTILATORY FUNCTION					
AMA class		<i>Class 1</i>	<i>Class 2</i>	<i>Class 3</i>	<i>Class 4</i>
Respiratory impairment		0%	20-30%	40-50%	60-90%
FEV _{1.0} & FVC-%*		85+%	70-84%	55-69%	< 55%
INSECTICIDE USE					
A. Consistent heavy use	50	16	19	9	6
B. No use to heavy use	23	5	10	6	2
C. Daily use to light use	20	6	7	6	1
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
A+B+C. Any heavy use in past 2 years	93‡	27	36	21	9
D. Consistent light use	49‡	25	13	10	1
	<hr/>				<hr/>
	142				
INSECTICIDE USE IN 81 OF THE ABOVE ADULTS WHO DO NOT SMOKE CIGARETTES					
A. Consistent heavy use	29	10	9	6	4
B. No use to heavy use	10	2	2	4	2
C. Daily use to light use	10	2	5	3	0
	<hr/>	<hr/>	<hr/>	<hr/>	<hr/>
A+B+C. Any heavy use in past 2 years	49‡	14	16	13	6
D. Consistent light use	32‡	18	8	6	0
	<hr/>				<hr/>
	81				

* % of predicted values for normal population by age, sex, and height.
† Statistical comparison of 93 persons in the 4 classes of respiratory impairment in households with heavy insecticide use (A+B+C) with 49 persons in households with consistent light insecticide use D. $\chi^2 = 8.486$, 3df, $p < .05$.
‡ Statistical comparison of same two groups without cigarette smokers. $\chi^2 = 14.872$, 3df, $p < .01$.

DEFINITIONS

Although habits and needs do vary in time, most people had a consistent pattern of insecticide use. To classify use, once a week or oftener is defined as heavy use. Less than once a week is defined as light use. By this definition, 30 of 44 original daily use households were found two years later to be still applying insecticides heavily. The other 14 households, using insecticides less frequently, either had fewer insects or became more tolerant of those they had. Similarly, 32 of 46 original no-use households were consistent in that they were still not applying insecticides frequently, but were applying as often as the large majority of our population, monthly to yearly. This consistent light use group is thus representative of the total original sample. The other 14 original no-use households were found two years later to be applying insecticides frequently, about half having been reluctant to admit the need or the practice when first questioned, though using heavily all along. The other half had only recently begun frequent use.

Respiratory impairment is classified according to the AMA Committee's rating scale.² It is based on two tests of respiratory function performed on the spirometer; flow rate or forced expiratory volume in the first second (FEV_{1.0}) and forced vital capacity (FVC). Normative standards give the expected performance based on age, sex, and height. Class 1 includes those with least impairment and 85 to 100 per cent of expected function.

Class 2 includes those with 20-30 per cent impairment and 70-84 per cent of expected performance. Class 3 is defined as 40-50 per cent impairment with 55-69 per cent of expected function. Class 4 includes those with most impairment (60-90 per cent) and less than 55 per cent of expected respiratory function.

OBSERVATIONS

All individuals 20 years of age or older and without acute respiratory illnesses are compared in Table 1, which gives the rating by respiratory impairment for persons in each category of insecticide use. The consistently light-use group is found to perform significantly better than those in households using insecticides heavily in the past two years ($p < .05$). When persons in the same groups are compared, excluding those who smoke cigarettes, a greater difference is found ($p < .01$).

There was no definite correlation of impairment with any specific agent. Multiple and changing use of different types of insecticides in spray form was the common pattern observed. No other environmental variable was found to correlate with the observed differences in respiratory impairment.

For those persons eligible for household visits in the summer of 1967, but relocated or not seen, records available from the original survey (1965) were reviewed to see if any obvious biases were present. Cases of asthma and chronic sinusitis reported in 1965 but not visited in 1967 were found to be distributed between heavy-use and no-use

TABLE 2.—*Respiratory Symptoms and Insecticide Use at Home for 380 Persons.*

INSECTICIDE USE	Total	NUMBER OF PERSONS WITH CURRENT SYMPTOMS*			
		Asthma	Chronic sinusitis	Chronic bronchitis	Perennial nasal allergy
A. Consistent heavy use	156	16	6	5	18
B. No use to heavy use	50	3	3	0	5
C. Daily use to light use	62	2	1	4	4
A+B+C. Any heavy use in past 2 years	268	21	10	9	27
D. Consistent light use	112	1	1	0	9
	380				

* Statistical comparison of persons with and without respiratory conditions in the two groups, 268 heavy insecticide users and 112 consistent light users. $\chi^2 = 15.191$, 4df, $p < .01$.

households in proportions similar to those we report below. We conclude therefore that no important out-migration biases are present.

Respiratory conditions defined by presence of symptoms during the previous year are listed in Table 2 by insecticide use. Asthma is defined as having more than one spell of wheezing during this time. Chronic sinusitis refers to continuing symptoms of sinus pain and discharge. Chronic bronchitis is defined as chronic productive cough throughout the year. Perennial nasal allergy is the designation for sneezing or nose-itching plus nasal discharge most days of the year. Persons are placed in only one category. Of seven adult asthmatics, five have associated bronchitis. Half of all asthmatics have perennial nasal allergy as well. Asthma and chronic sinusitis are found preponderantly in the consistently heavy-use group. Perennial nasal allergy is twice as common in this group. Persons living in households using insecticides frequently have significantly more respiratory conditions than those persons living in households where insecticides are used infrequently ($p < .01$). Physical findings and history of insecticide use are consistent with the evidence associating pesticide use and respiratory conditions.

Both reduced ventilatory function and a higher prevalence of asthma are found to be associated with frequent application of spray insecticides. No single compound or combination used has been implicated. Most commonly used is a combination of pyrethrum, piperonyl butoxide, and petroleum distillates. The next most common type of combination used contains DDVP, an organic phosphate, and dieldrin, a chlorinated hydrocarbon, each in 0.5 per cent concentration, plus petroleum distillates.³ Pyrethrum as mosquito punk or coil is often used in addition to other products. Pyrethrum has long been used and is available in about 2,000 varieties of sprays.⁴ It is thought to have allergic effects.^{5, 6, 7} Organic phosphate compounds are reported to be capable of producing nasal discharge and occasional wheezing.^{8, 9}

MUST WE SPRAY?

While flies and mosquitoes are a seasonal problem on the mainland, they are present the year round in a tropical climate. Cockroaches are a year-round problem in both areas, but spraying individual cockroaches is a wasteful, ineffective, and irrational way of suppressing them. Poisoned bait in tablet form is far more effective. No space sprays are recommended by the U.S. Public Health Service for regular indoor use. Sprays are convenient to use, and may satisfy certain hostile impulses, but their use rarely reduces insect infestation. Baits and repellents are far more effective, and safer.

Our evidence shows association between frequent use of household insecticides and respiratory impairment. To test for causal effects of specific components of the sprays, inhalant challenge to volunteers is necessary.

REFERENCES AND NOTES

1. No suggestive findings were observed for the following chronic conditions: tuberculosis, rheumatic fever, hardening of the arteries, high blood pressure, stroke, varicose veins, hemorrhoids, benign tumor, chronic gall bladder or liver trouble, kidney stones or chronic kidney trouble, mental illness, arthritis, diabetes, thyroid trouble, other allergy, epilepsy, chronic nervous trouble, cancer, chronic skin trouble, hernia, prostate trouble, palsy, paralysis, or congenital condition.
2. Committee on Rating of Mental and Physical Impairment: The respiratory system, JAMA 194:919-932 (Nov. 22) 1965.
3. DDVP is 2,2-dichlorovinyl dimethyl phosphate. Dieldrin is not less than 85% of 1, 2, 3, 4, 10, 10-hexa-chloro-6, 7-epoxy-1, 4, 4a, 5, 6, 7, 8, 8a-octa-hydro-1, 4-endo-exo-5, 8-dimethanonaphthalene.
4. Gleason, M. N., Gosselin, R. E., and Hodge, H. C.: Clinical Toxicology of Commercial Products, Baltimore, Williams & Wilkins Co., 1963, pp. 131-132.
5. Garratt, J. R., and Bigger, J. W.: Asthma due to insect powder, Brit. Med. J. 2:764 (Oct. 27) 1923.
6. Feinberg, G. M.: Pyrethrum sensitization: its importance and relation to pollen allergy, JAMA 102:1557-1558 (May 12) 1934.
7. Sheldon, J. M., Lovell, R. G., and Mathews, K. P.: A Manual of Clinical Allergy, ed. 2, Philadelphia: W. B. Saunders Co., 1967, p. 451.
8. Koelle, G. B.: Anticholinesterase Agents, in Goodman, L. S., and Gilman, A.: The Pharmacologic Basis of Therapeutics, ed. 3, New York: Macmillan Co., 1965, Chapt. 22, pp. 447-454.
9. Grob, D.: Manifestations and treatment of poisoning due to nerve gas and other organic phosphate anticholinesterase compounds, Arch. Intern. Med. 98:221-239 (Aug.) 1956.
10. Supported by USPHS grant PH 86-65-79. We thank Eileen Shimatsu Cabente and the Hawaii State Department of Health for their help. ■

Craniostenosis in One Dizygotic Twin

H. WILLIAM GOEBERT, JR., M.D.,* Honolulu

THE ETIOLOGY of premature closure of the cranial sutures, or craniostenosis, is not known. The developing brain provides the impetus for enlarging the skull. If a defect occurs in the mesenchyme designed to form the sutures, they may fuse prematurely.

Giblin and Alley¹ showed that a bone bridge placed across a suture in animals leads to complete fusion. Thus in craniostenosis most likely the defect is in the suture itself and not in the cranial bone.

Familial instances of craniostenosis are sporadic. About ten per cent have positive family histories. Bell, Clare, and Wentworth² presented two cases with positive family histories—one having two children with scaphocephaly (premature closure of the sagittal suture), the product of one mother and separate fathers; the other having three children with scaphocephaly, with the father, paternal cousin, two paternal uncles, and paternal grandmother also having scaphocephaly. Shannon³ has traced a family which had 13 members involved in four generations. A review of 40 cases of craniostenosis by Pemberton and Freeman⁴ had

four with a positive family history. In seven cases seen at the Straub Clinic there was no family tendency.

Bell *et al*² state that Virchow in 1851 remarked that possibly intrauterine changes were the cause of craniostenosis.

A two-and-one-half-month-old boy was first seen by a pediatrician for a routine check-up and also because of an abnormally shaped head. This child was a younger twin, the elder being a girl. This was the first pregnancy for the mother, who had had a normal prenatal period and normal delivery. The mother and a maternal uncle have long narrow heads. It was noted at the time of delivery that the child's head was unusually shaped, but it was felt with the passage of time it might improve. The child was perfectly healthy otherwise and was eating and gaining weight. Its dizygotic twin sibling was doing well and had a normally shaped head.

The patient's head at the time he was first seen by me was scaphocephalic, with an AP measurement of 15 cm and a biparietal measurement of nine cm. He had an open anterior fontanel and there was a ridge running along the sagittal suture. Skull x-rays revealed the sagittal suture to be com-

* The chromosomal studies were done without charge in the Department of Laboratories at the Queen's Medical Center.
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pletely closed (Fig. 1). A linear sagittal craniectomy was done when he was three months old.

Chromosomal studies* disclosed no abnormalities.

SUMMARY

This is the first known case report of a dizygotic twin with scaphocephaly. McLaurin and Matson⁵ mention that one of their cases was a twin but do not give further information.

CONCLUSION

The occurrence of a dizygotic twin with scaphocephaly makes an intrauterine cause of this disease unlikely in this patient. It is hoped that further studies may shed more light on the etiology.

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REFERENCES

1. Giblin, N., and Alley, A.: Studies on skull growth: coronal suture fixation, *Anat. Rec.* 88:143-153, 1944.
2. Bell, H. S., Clare, F. B., and Wentworth, A. F.: Familial scaphocephaly, *J. Neurosurg.* 43:239-241 (Mar.) 1961.
3. Shannon, Edward: Personal communication.
4. Pemberton, J. W., and Freeman, J. M.: Craniostenosis: a review of experience with forty patients with particular reference to ocular aspects and comments on operative indications, *Amer. J. Ophthal.* 54:641-650 (Sept.) 1962.
5. McLaurin, R. L., and Matson, D. D.: Importance of early surgical treatment of craniostenosis: review of thirty-six cases treated during the first six months of life, *Pediatrics* 10:637-652 (Dec.) 1952. ■



FIG. 1.—Lateral skull x-ray shows an open fontanel and an open coronal suture. There is a long “keel-shaped” head.

Give
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*Hippies are people, often very likable people,
but their way of life is not conducive to health.*

The Living Environment of the Beaded, Sandaled, and Hirsute

DONALD F. B. CHAR, M.D.,* Honolulu

AS A college physician, I rarely see the true hippie—one who has “turned on, tuned in, and dropped out.” However, I see many students on the fringes of this subculture, and others in the process of dropping out of the University. Our newspapers and magazines remind you that our colleges are characterized by many forms of deviant behavior. In addition, the greatest health concern on any college campus has traditionally been, is, and probably will be in the future, the problems relating to sexual behavior and drug taking,¹⁻³ the hallmarks of the hippie subculture, I would again remind you. I would point out that an earlier generation had its equivalent to drug taking in liquor and beer busts.

So with these factors in mind, I felt I had some expertness in this field, and accepted this challenge to deal with a most important health problem. I had the opportunity to follow up my personal observations on a portion of this subculture in Honolulu with a visit to Seattle and Minneapolis, and also spent a day at a medical conference on drug involvement held by the Haight-Ashbury Medical Clinic in San Francisco, the hippie capital of the world. I now feel somewhat more competent to share my prejudices with you.

I deliberately say prejudices because I have been accused of being judgmental in the areas involving drug and sexual freedoms, and I need to underline that it is impossible for me to speak objectively to the facts without admitting value implications on my part. It is virtually impossible to speak on these subjects without revealing some personal bias. I am greatly concerned when people do not realize that this is the basis for their thoughts and behavior.

I hope you will forgive me for some of my language and my use of descriptive phrases, for these are necessary to give you a feeling for these people. My personal contacts with some of these

hippies on campus leave me with negative impressions of what they do to themselves and what they also mean to all of us in society, and visits to other mainland cities have merely reinforced my opinions, I am afraid. So let me warn you that I find fault with the lifestyle of the hippies. I believe that most systematic, orderly people, regardless of age, would. This situation probably accounts for the fact that no one likes to be called a hippie. Here, I would want to distinguish between objectively finding defects in their way of living, as different from reasons they offer for living the way they do.

As Jane, one of the conference speakers representing a “hippie element” at the Haight-Ashbury Medical Clinic, stated: “I hate the kids on Haight Street. All they can think about is f---ing and dropping acid.” She went on to say that she was taking LSD, which allowed her to drop out of a meaningless life of typing insurance forms, and she was happy now—unemployed, but happy “doing her thing.”

I could readily see why she wanted to disengage herself from the Haight-Ashbury scene. Being a physician, I have seen my share of shocking, depressing sights. But I was unprepared for the view of Haight Street at 11:30 on a Saturday morning. The sidewalks were congested with these people—dirty, offensive-smelling, unkempt; many with blankets or serapes wrapped around themselves; many youngsters; largely males, but surprisingly, many females. They were strung along the sidewalk in groups so that you had to continuously pass among them. Many of them had dogs, whose excreta were evident on the sidewalk. Infants and toddlers were very much in evidence. Particularly impressive was the begging that was going on. As one walked through this crowded sidewalk, virtually every third or fourth individual was saying “loose change?” I didn’t understand this at first, but after half a block, when several of them stuck their hands out at the same time, I got the message.

I relate this impression to set the mood for this paper. To cope with this subculture, you must al-

Presented as a talk to a Hawaii Public Health group in a conference on “Man and His Total Environment,” May 9, 1968.

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low for excesses in language, in attitudes, in behavior. Obviously, you should not plan to deal with the individuals in this subculture in any "normal" fashion. Being a pediatrician, I feel somewhat at ease with these people, for they represent examples of deviant adolescents—the romantic idealist who is unaware of the total nature of himself and the world, so that what he practices and what he preaches are frequently at odds with each other. Even though I obviously disapprove of this development in our society, I nevertheless feel impelled to help them, for they are fundamentally "good" people; many of them need us, and we can help. What usually worries me is that they often feel that they have a "superior" way of life, and all too often, have to meet with unpleasant, harsh realities of life before they are ready for more meaningful relationships.

THE HAIGHT-ASHBURY SCENE

Against this backdrop, let me now try to present what I have learned from others, as well as from my experiences, concerning this subculture. I intend to draw upon the information and exposure I had at the "Hashbury" conference, for this large collection of deviant human beings has already created many problems in public health.

Dr. David Smith, the Medical Director of the Haight-Ashbury Medical Clinic, reminds us that "Hashbury" is not dying out. The population has remained the same, at its level of around 15,000, and in the summer, this figure soars to five or more times this number.

These are transient individuals, always on the move, continually following their every whim and desire, living in "Hashbury" for a while, then moving on to the Big Sur country. But they soon tire of this scene, so they hop a plane to come out to Hawaii, or go north to Seattle or east to Greenwich Village in New York City. Many of these individuals continue to receive money from home, which helps account for their great mobility, as well as their perseverance in this form of life.

Obviously, counting these bodies is well nigh impossible, and therefore numbers and statistics become difficult to assess. You therefore cannot find good data and hard facts to support all of your statements—which is why everyone can be an expert on the subject: there are few real facts to refute him. However, some facts are established.

DRUGS

Drugs are an indispensable part of this subculture. Dr. Smith says that current research shows that 97 per cent of the males and 95 per cent of the females have taken, or are taking, marijuana.

He sees few medical consequences of this form of drug taking, although he occasionally sees an acute intoxication syndrome, much like a drunk. However, as is obvious from his statistics, hippies in Haight-Ashbury do not restrict their use of drugs to marijuana alone.^{5, 6}

The amphetamine group of drugs creates the most serious problems currently. "Speed Kills" is literally true. The most prevalent form of this drug is methedrine, also called "speed" or "crystal."

Apparently, many of the hippies in "Hashbury" have had contact with this drug. They take relatively large doses of this substance in order to get a "high" or a "flash." This "high" is invariably followed by a withdrawal depression and profound fatigue. Tolerance is built up; so in order to prevent these uncomfortable sensations, they go to higher and higher and more frequent doses, culminating in "shooting" it—or injecting it intravenously, as the narcotic addicts do.

So hepatitis is a common disease of Hashbury.⁷ Skin infections and abscesses are also commonly seen. Because this self-abuse with drugs generally goes on for three or four days without interruption and without sleep, these individuals become exhausted. As you recall, this drug is an appetite depressant, so these individuals fail to eat, and become badly malnourished. Paranoid-schizophrenic psychoses appear in the chronic state, and many of these individuals need hospitalization.

LSD is commonplace; about 80 per cent of the hippie community have used or are using it. The recent discovery that it may cause chromosomal abnormalities may seem like a good reason why none of us would take it. However, the two individuals from Hashbury, Jane and Bob, who insisted that LSD helped them with their personal problems, seemed to reject this evidence. They had heard Dr. Maimon Cohen, one of the original researchers who discovered the cytogenetic implications,⁸ say that this finding needs to be further confirmed and extended—which to them means that these findings are meaningless at this point. This type of rationalization is interesting, for many of these people seem often to reject unpleasant facts or redefine them to a point where they can accept them.

Dr. Smith stated that opiates had previously been a negligible problem among the inhabitants of Hashbury—but the problem has increased, so that he feels that it no longer is negligible, but now ranks as a "small" problem.

The critical issue, Dr. Smith reminds us, is that no one knows how to identify the addictive personality: no one knows how to spot the budding alcoholic or the potential drug addict, and there-

fore no one can predict who can safely use, without abusing, these drugs. So the final evaluation of marijuana and these other drugs must await more research and the passage of time, and the results must be open to sharper and more critical scientific analysis, rather than newspaper story releases.

V.D.

The other major medical problem seen by the Haight-Ashbury Medical Clinic is venereal disease. However, they know nothing of its prevalence although they feel it to be a major health problem. They refer all patients to the San Francisco Health Department VD Clinic. There is no attempt by this Clinic to do contact work or even think of prophylaxis, and the Clinic administrator was not aware of what the Health Department did in this area either. He was skeptical that anything meaningful could be done because of the basic mistrust these individuals have for government workers. Hippies are generally so transient and mobile that they also defy identification and follow-up, and would frustrate most public health officials who tried to help them through standard channels.

The most common medical ailments seen at this Clinic are the usual respiratory disorders and skin afflictions, but the malnutrition evident in this population serves to intensify and worsen all manifestations of disease. Therefore, these individuals commonly end up with pneumonia or skin abscesses as serious complications.

BAREFOOT IN HAWAII

In common with San Francisco, Seattle, Minneapolis, or any other large American city, we have our share of hippies in Hawaii. As stated above, there are all degrees and shades of them. My comments will be largely based upon my student contacts at the University of Hawaii Student Health Service.

The ultimate or "true" hippie who not only has turned off and tuned in, but has dropped out completely, is to be found scattered throughout Honolulu, largely concentrated in the Waikiki areas. However, these individuals are increasingly now found living in many parts of rural Oahu as well as on Maui, especially the Lahaina area, and Kauai. Many of these hippies are trying to get back to nature and are living in rather primitive circumstances, very unlike the urban setting of the Hashbury hippies.

I intend to share my personal experiences with you in the form of specific anecdotal case reports. I hope that these individual case reports will serve to reinforce the point that this group

is made up of human beings, everyone with different characteristics and needs.

"JOHN"

The first hippie I ever befriended at the University, three and a half years ago, was John. He had just come into town from San Francisco, and was a marginal student, lacking any real goals for his academic existence on campus. Like others, he came from an upper middle-class family in California, his father being an engineering consultant. By the time he was 13, he was roaming freely around California, living off nature, returning home only during school periods. He had not seen his parents for over two years when I first got to know him, although he periodically still received a check from home.

I initially saw him for the problem of an exudative tonsillitis, and judging from his story, quite a few of his housemates also had the same problem, but could not afford medical care. He was living at this time in a private two-bedroom home on Pacific Heights, but when his initial group of three expanded to fourteen, including one child, the landlord felt it was time to evict them. So they all dispersed. John ended up with his "old lady," a vagabond folk singer, mother of the child. In the year that I knew John, he saw me on many different occasions for sore throats, skin infections, and, on one occasion, gonorrhea. On this latter occasion, I tried to assist him by offering to see or refer his "old lady" for medical care, but he said that she didn't give him the disease and he promised not to have intercourse with her until I had completed my treatment.

Like many hippies I have known since, John was characteristically friendly and open as soon as I showed interest in him as a person. However, you must not become too optimistic that your relationship will alter their lives; like John, many of them fail to live up to their goals and just move on.

"BETTY"

Betty was a rather classical hippie girl from Oakland, California, by way of Hashbury. She was only 18, and had already lived in this subculture for over two years when I got to know her.

She came in on a Saturday morning for her first visit wearing a plain shift, shoeless, with beads around her neck and leather ringlets around her ankles. I found her very appealing, rather like a poor little lost girl.

She complained of frequency and burning on urination, but her urinalysis was normal. So I began to speak to her about herself and her personal problems. She very readily did this, and I found

that she was unhappy with her "old man." He apparently was a classical hippie, having completed the dropout, and all he did every day was to play the piano. They lived on her monthly allotment from her parents, and had great difficulty keeping an apartment.

Her boyfriend saw no need to work, so he contributed no money to their existence. In addition, their sexual life was more than she wanted, and she was trapped between this problem of totally rejecting him or not having anyone around to "care" for her.

In view of these problems and the negative clinical findings, I reassured her that she did not have cystitis, and did not treat her with medication, but made an appointment for her on Monday to follow up the problem. She had told me that she was seeing someone in our Counselling Center, and I wanted to see what was being done, before planning a full attack on the problem.

She never came back that Monday, but returned about two weeks later, this time asking for me alone. I was not available at this time, so she went off campus to a private physician for care, refusing to see anyone else in the health center. This is another common characteristic of these people: they basically mistrust institutions and agencies. She failed to respond to treatment by this physician, and a week later she again showed up to ask for me.

She appeared ill and listless at this point, so I pressured her into accepting bed care in our infirmary.

I could not find the cause for her illness, even calling in a consulting gynecologist, but she had improved sufficiently by this time so that I agreed to let her out to be followed in the clinic. In the meantime, I had reinforced the urgency of her need to care for herself by speaking to her "old man"—who incidentally was now working daily in our cafeteria washing dishes, and thus at least paid for his own meals, which improved their relationship greatly.

A week later, she developed the classic findings of a bladder infection again, and on examination, I could see some evidence of a vaginal discharge. Smear of this discharge proved to be gonorrheal in origin.

Now the story unfolded: she had gone back to Hashbury about two weeks previously, had met one of her old boy friends, and had intercourse with him. This in spite of the fact that he had given her gonorrhea a year ago!

Discussion of how and why she got involved again with this old acquaintance revealed a deep pathologic history of a girl using her body to promote personal relationships. She never enjoyed

sexual relationships and had never experienced an orgasm.

After I treated her gonorrhea and referred her "old man," who was asymptomatic, to Kapahulu VD Clinic, I found that she planned to drop out of school. Her reason? Just confusion about herself and her goals.

Incidentally, she did not take drugs at all now. In fact, she had taken none since she left San Francisco, because she said it "mixed her up even more." I find this phenomenon of the ex-drug taker more and more common in my practice on campus.

"RICK"

Rick was a 22-year-old dedicated "drug taker." He took "trips" all the time, living with his older brother in the Waikiki "Jungle."

He served as my source of much information about the drug scene in Waikiki while he was here, and pointed out the difference between the real hippies and the false or "plastic" hippies in Honolulu. He stated that the motoreyele gangs and the surf bums were really taking advantage of the scene and were bad for everyone.

He flunked out of school eventually, and the last I heard of him was by way of a physician in California who inquired into my medical knowledge of his problems.

"JIM"

I saw Jim in the Clinic complaining of a severe diarrhea. He had been staying with a family of two adults and four children in a home on the outskirts of a small town on Maui, much removed from civilization and therefore having no municipal source of drinking water. The home was infested with rats and mice and the sole source of drinking water was from a cistern collecting rain from the roof. He said that rodents were frequently heard and seen travelling in the rain gutters, and although he saw no overt evidence of rat pollution of the water, he was quite convinced that they all drank grossly contaminated water.

He developed a bloody diarrhea on the second day of his stay in Maui and it persisted. The family inhabiting the home was all down with this complaint, the youngsters had a fever, and his three friends accompanying him were also similarly afflicted.

With such an overwhelming story of a need for some medical and public health measures on Maui, I urged him to tell me the names and location of these people so I could notify our Health Department, thinking that they could attempt to assist these people on Maui. Jim refused, saying that they did not trust "government people." No

amount of discussion could break down this decision. I saw him on two other occasions for this acute illness, and when the single stool culture we took was reported to be negative for enteric pathogens, he never returned, and to this day, we do not know what he did to notify the family on Maui as to their personal health needs.

This story again emphasizes the great mistrust that so many of these hippies have for governmental agencies. Much of this feeling is irrational, as illustrated by this case of Jim, but it remains a fact that you cannot deal meaningfully through normal channels with many of these individuals.

DISCUSSION

Having shared these personal experiences with you, I hope you can now see why I often despair of this subculture when I deal with one of these people. Nevertheless, I would remind you that we have all integrated parts of this movement into our established ways (establishment?), for I see more beads and long hair every day among us. The strength of humanity, I am sure, rests in our ability to accept, and in fact, to incorporate contributions from everyone into our constantly changing society.

Nevertheless, as thoughtful, compassionate human beings, especially those of us with the heavy burden of public health responsibilities, we have the great task of trying to identify what is viable and meaningful for society and to reject and deal with the harmful. I am particularly distressed by many sincere and obviously well-intentioned people in society who overemphasize the virtues and so distort the problems that emotionalism emerges and the elements in the community polarize to "choose sides." Our work of trying to assist people with their problems then becomes so embroiled with passionate controversy that rational, realistic judgments and solutions can never be reached. As mentioned above, many of these hippies remain beyond our reach because they feel that they are living a better "life" than we are.

For instance, one of our local ministers has published in one of the local newspapers the following description:⁹

"The scene? It's a microcosm of the youth revolution throughout the nation. Outwardly it's long hair and beards, girls with no shoes but bright colored shawls, psychedelic posters, incense and Indian music. Much of this I find refreshingly beautiful.

"The friends who are sharing their pad and food with me would certainly be looked strangely upon by most of your neighbors, but these are kind, accepting and creative people. They are

gentle people. Gentle with each other and gentle with me.

"The scene is so much more than outward appearances. Underneath the long hair and unusual clothing there is a profound value revolution taking place.

" 'Straight' people look upon their communal living, their lack of enthusiasm for holding down an 8:00 to 4:30 job, and their sexual and verbal permissiveness as immoral. Yet the meaning of a moral life is a crucial concern among these drop-outs from middle-class society."

I suggest that we need to look at this hippie subculture with more meaningful criteria, particularly in the area of activities. We tend to become confused when we address ourselves solely to the question of reasons and motivations for their lifestyle, and often forget the importance of having to deal with the everyday health problems that they present. As public health workers, we cannot afford to look at them through the rose colored glasses of romantic idealists, for we all have the responsibility of providing services for the entire community. Many of these hippies are troubled adolescents and young adults, searching for a meaning for their existence, and I am convinced that most of them will eventually find a more meaningful and functional lifestyle. What distresses me most is that we are seeing evidence that this disenchantment and acting out is moving into the younger age groups.

In dealing with them, one must look beyond the long hair and beads and superficial behavior, and learn how to relate to and communicate with them as individuals. Even then, you may not understand them at all, but in trying to communicate with them, you will find rewarding experiences, as I have. I am convinced that the majority can be opened up to meaningful dialogue, and some can be helped. The methods you may have to employ, by necessity, will have to be highly individualized and personalized.

REFERENCES

1. Abelson, P. H.: LSD and marijuana (an editorial), *Science* 159:1189 (Mar. 16) 1968.
2. Imperi, L. L., Kleber, H. D., and Davic, J. S.: Uses of hallucinogenic drugs on campus, *JAMA* 204:1021 (June 17) 1968.
3. Farnsworth, D. L.: The drug problem among young people, *W. Virginia Med. J.* 63:433 (Dec.) 1967.
4. Schubart, P., Smith, D., and Conrich, R.: The concept and design of a regionalized health facility for the Haight Ashbury subculture, *J. Psychedelic Drugs* 1:53, 1967.
5. Marijuana and society: statement of Council on Mental Health and Committee on Alcoholism and Drug Dependence of AMA and Committee on Problems and Drugs Dependence of the National Research Council, National Academy of Sciences, *JAMA* 204:1181 (June 24) 1968.
6. Eddy, N. B., *et al*: Drug Dependence: Its significance and characteristics, *Bull. WHO* 32:721 (May) 1965.
7. Barrett, P. V. D., and Boyle, J. D.: Hippie Hepatitis, *Mod. Med.* 36:42 (July 1) 1968.
8. Cohen, M., Hirschhorn, K., and Frosch, W.: In vivo and in vitro chromosomal damage induced by LSD 25, *New Eng. J. Med.* 277:1043 (Nov. 18) 1967.
9. Jones, L.: "Hippie" Center of the Nation, *Honolulu Advertiser*, B2 (April 9) 1967. ■

A "day" hospital for mental patients is a going concern in Honolulu; here is a look at its patient load and results.

Disposition of Day-Hospital Patients

A Six-month Cohort Analysis

DONALD H. DEKREY, Ph.D.,* Bemidji, Minnesota

● *The "typical patient" in the Diamond Head Mental Health Center Day Hospital is a Japanese man over 40 with schizophrenia. The population is significantly more Japanese and Chinese and less Caucasian than the general population. About one-third of patients terminated their hospitalization in a six-month period; one-third of these were transferred to outpatient status, one-third because of employment or educational needs, and one-third for unknown reasons.*

PROGRAM evaluation is always difficult to approach. This is particularly true when attempting to evaluate the effectiveness of a day hospital which offers a myriad of treatment modalities to a group of mental patients who can best be called "chronic."

The Diamond Head Mental Health Center Day Hospital (formerly Convalescent Center) offers a broad approach to the treatment and maintenance of chronic mental patients. Treatment methods range from drug intervention and maintenance, through socialization and individual and group therapies, to occupational training and job placement. Patients are assigned to the Day Hospital (DH) for indeterminate periods of from one to five days per week.

Most of the patients who are referred to the DH are former Hawaii State Hospital patients who are felt to be in need of further "socialization." The process of socialization is considered the most important single aspect of treatment and tends to be the basic underlying goal in most of the approaches used. The length of stay for any

individual patient is largely open-ended. Consequently, termination of contact with the DH is left to a decision by the patient, the patient and his physician, or the patient and his social worker.

Because of the relatively informal nature of the DH assignments and the close interaction between patients and staff, it was felt that a six-month cohort analysis might answer some of the questions concerning the effectiveness of the DH approach. A cohort is simply a group of individuals who have one or more characteristics in common, all of whom are followed over a specified period of time. The cohort selected for study in this instance was all of the patients (145) who attended the DH in the month of September, 1967. These patients were followed for six months, until March 1, 1968. The disposition of these 145 patients is reported in this paper.

GENERAL DESCRIPTION OF COHORT

Sex: A division of sexes reveals 81 men attending the DH as compared to 64 women. This division of men and women patients is approximately the same as that reported by the Hawaii State Hospital for the 1965-66 fiscal year.

Age: The average age of men attending DH at the beginning of the cohort was 40.3 years. The range of ages was 14 to 69. A standard deviation of 11+ indicates that two-thirds of the men were between 29 and 51 years of age.

The average age of women attending DH was 43.5 years. The range was 19 to 72. Again, a standard deviation of 11+ implied that two-thirds of the women were between 31 and 54 years of age.

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TABLE 1.—*Marital Standing.*

		MARRIED	NEVER MARRIED	OTHER*	TOTAL	CHI-SQUARE	SIGNIFICANCE
Men	observed (f_o)	11	63	7	81	70.2	$P < .005$
	expected (f_e)	47	30	4	81		
Women	observed (f_o)	24	23	17	64	26.1	$P < .005$
	expected (f_e)	43	14	7	64		

* Includes divorced, separated and widowed.

The slight difference in mean age between men and women proved to be statistically nonsignificant.

Marital Standing: Table 1 represents the marital standing of the patient cohort. The "expected (f_e)" figures in Table 1 were calculated from U.S. Census data. It was assumed that the same proportions reflected in the general population of the state of Hawaii should be seen in the cohort population.

Table 1 indicates that the "singleness" of DH patients is a highly significant finding. This appears to be true of both men and women, but is most significant in men. At this time it cannot be stated whether this finding is related to the type of program offered by the DH or is a function of mental illness, particularly schizophrenia. Further investigation is needed to clarify this point.

Diagnostic Categories: Table 2 indicates the diagnostic division of the patient cohort at the beginning of the study. It is readily apparent from Table 2 that the predominant diagnosis is schizophrenia, with all other categories represented in only a minor degree. This finding is quite suggestive of a chronic population.

Ethnic Patterns: Although all of the major ethnic groups represented in Hawaii are also represented at the DH, only the major ethnic divisions are represented in sufficient number to calculate significance of representation. Table 3 indicates the division of the major ethnic groups in the cohort population.

Chi-square analysis of the data in Table 3 reveals a highly significant over-representation of Japanese in the DH population, as well as a highly significant under-representation of Caucasians. Of possible significance is the over-representation of

Chinese in the DH cohort. Although there is no ready explanation of these findings, it appears likely that the DH "pulls" certain ethnic groups. Of possible significance is the fact that 55 per cent (six out of eleven) of the treatment staff is of Oriental extraction. This "over-representation" of Orientals on the treatment staff may be related to the over-representation of Orientals in the patient group. This line of reasoning does not hold true for the Caucasian group. Caucasians are represented on the staff at about the same rate as in the State population. Further investigation will be needed to clarify the low incidence of Caucasian attendance at DH.

Hospitalization Patterns: The chronicity of the cohort population is readily apparent when it is noted that nearly all of the patients have been patients at Hawaii State Hospital one or more times. The range of hospitalizations was from 0 to 13 admissions. Men patients had a mean number of hospitalizations of 3.25. Women had been hospitalized an average of 3.46 times.

DISPOSITION OF THE COHORT POPULATION

The foregoing population was followed for a six-month period, dating from September 1, 1967, until March 1, 1968. At the close of this period of time, the disposition of all of the 145 patients was determined and is shown graphically and numerically in Figure 1.

Figure 1 summarizes the six-month disposition of the 145 patients in the cohort population. It is readily apparent that about two-thirds of the patients who were enrolled in the program on Sep-

TABLE 2.—*Table of Diagnosis.*

DIAGNOSIS	NUMBER	PER CENT
Schizophrenia (all types)	109	75.6
Chronic brain syndrome	10	7.0
Depression	9	6.3
Neurotic reactions	8	5.8
Involuntal psychosis	5	2.5
Manic-depressive	2	1.4
Other	2	1.4
Total	145	100.0

TABLE 3.—*Ethnic Representation in the Cohort Population.*

ETHNIC GROUP	DH PER CENT	STATE PER CENT*	SIGNIFICANCE
Japanese	47.6	30.3	$P < .005$
Hawaiian, Pt.-Haw'n.	13.8	18.4	non-sig.
Chinese	11.7	8.1	$P < .05$
Caucasian	8.3	28.7	$P < .005$
Other	18.6	14.5	non-sig.

* Calculated from *The Population of Hawaii, January, 1967*, Statistical Report 47, Department of Planning and Economic Development, 426 Queen Street, Honolulu.

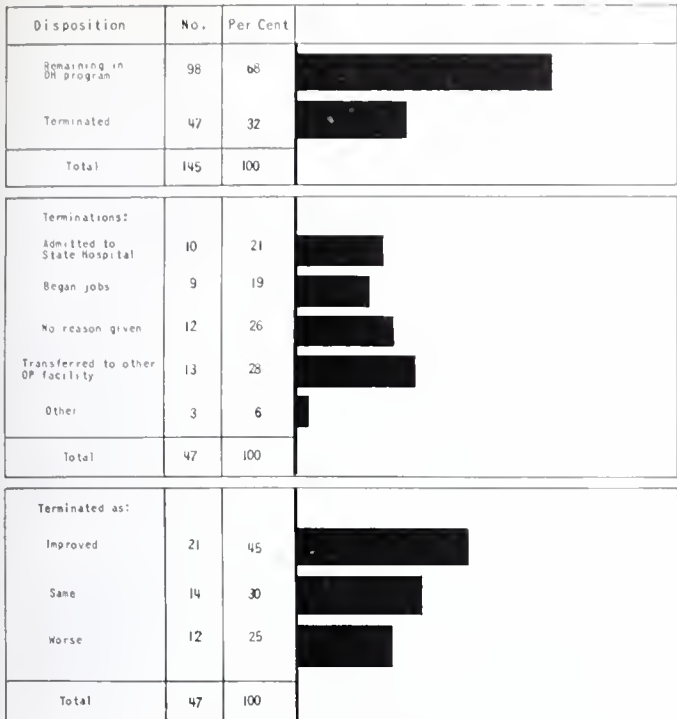


FIG. 1.—Six-month disposition of cohort population.

tember 1, 1967, were still coming to the DH at the end of the six-month study period.

Of the 47 patients who were terminated, only ten were admitted to the State Hospital. Twelve of the 47 merely stopped attending DH and gave no reason for their discontinuance. Thirteen of the patients were transferred to outpatient status, either at the Convalescent Center or at other outpatient facilities in the state. Nine of the patients began full or part-time jobs, making attendance at the DH impossible or impractical. The three patients in the "other" category included a teenager who resumed his education, one patient who remarried, and one who terminated as a result of an altercation with another DH patient.

Figure 1 also shows staff judgment of the mental status of all of the patients who were termi-

nated in the six-month period. Forty-five per cent of the terminated patients were judged to be "improved."

Table 4 reveals several interesting findings. It can be seen that men and women tend to terminate at about the same rate, with a slight advantage for the women. Both men and women tend to be younger in the terminated group. The difference is significant in women. Consequently, younger women are predictably more likely to terminate from the DH program than are younger men.

Table 4 also indicates a trend toward lower attendance rates in patients who terminate within a short period of time. Although this finding falls short of significance, a trend is certainly present.

The table further shows that patients who terminate have almost identically the same number of state hospitalizations as patients who remain in the program. Perhaps, unfortunately, hospitalization rates cannot be used as a predictor for termination or retention in this DH program.

Another interesting finding in Table 4 is significant in that it completely lacks significance. This is the fact that it appears to make no difference how far patients live from the DH as related to rate of termination. Within the general limit of seven or eight miles, distance does not appear to be a deterrent to attendance at the DH.

ETHNIC PATTERNS OF TERMINATION

Figure 2 indicates the distribution of major ethnic groups in the DH and the pattern of termination during the six-month observation period.

Figure 2 indicates the proportion of each ethnic group that terminated during the cohort study and those who remained in treatment. Only the "other" group (Portuguese, Korean, Puerto Rican) showed a larger proportion of terminations than retentions.

TABLE 4.—Descriptive Statistics of Patients Remaining and Terminated.

POPULATION DESCRIPTION	REMAINING IN PROGRAM	TERMINATED DURING STUDY	TOTAL	SIGNIFICANCE
Total cohort population	98	47	145	
Per cent of population	68%	32%	100%	
Men	57	26	83	
Per cent of men	69%	31%	100%	
Women	41	21	62	
Per cent of women	66%	34%	100%	
Mean age of men	40.9	37.9		P<.15
Mean age of women	46.1	38.3		P<.05
Average days per month of attendance for total cohort	10.5	7.3		P<.07
Average number of State hospitalizations	3.33	3.35		Non-sig.
Average number of miles traveled to DH	4.1	4.1		Non-sig.

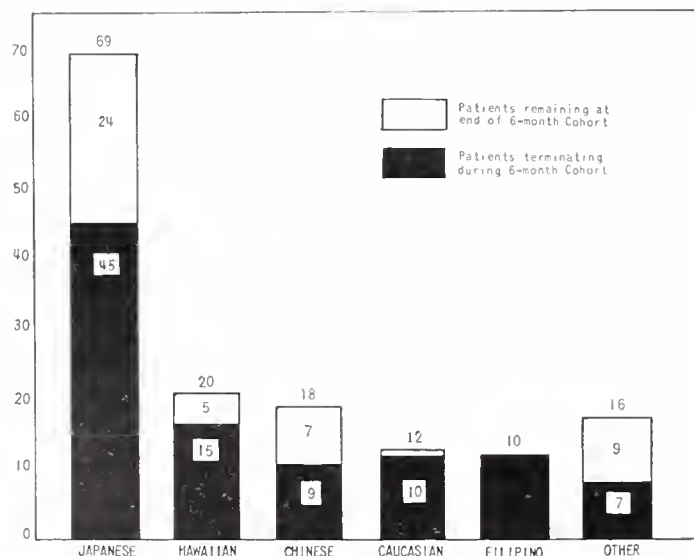


FIG. 2.—Ethnic distribution of patients terminating and remaining in DH treatment.

Although no relationship can be established, it can be noted that each of the designated ethnic groups have representation on the treatment staff. None of the groups in the “other” category are represented on staff. Again, one can speculate on the possibility of “staff pull.”

SUMMARY

The foregoing report is an attempt to evaluate the effectiveness of the Day Hospital approach as a treatment method for chronic mental patients. A cohort method of study was used, following the 145 patients enrolled in DH in the month of September, 1967, for a six-month period. The following observations are offered in summary as the essential findings of the study:

1. The patient population of the DH averages over 40 years of age, and 56 per cent are men.
2. Three-fourths of the patients are diagnosed as exhibiting the symptoms of schizophrenia.
3. There is a significant predominance of single over married people (particularly in the men) as compared to the State of Hawaii in general.
4. Japanese and Chinese people are significantly over-represented in the DH population. Caucasians are under-represented.
5. The “typical” patient could be described as a forty-year-old, single Japanese man with a diagnosis of schizophrenia.
6. Thirty-two per cent of the patients terminated during the six-month study period.
7. Men and women tended to terminate at about the same rate, with a significant finding that younger women tended to terminate most frequently.
8. Both termination and retention groups showed about the same number of State hospitalizations.
9. Distance traveled to the DH made no difference in rate of termination.
10. The possibility of “staff pull” was noted in the over-representation of Oriental ethnic groups in both staff and patient population and in the trend for ethnic groups which are not represented on the staff to terminate at a higher rate than groups which are represented on staff. ■

Upper Mississippi Mental Health Center, Bemidji, Minnesota, 56601.

Register for the
HMA's 113th Annual Meeting
Hilo
May 21-24

The President's Page



COME TO THE FAIR!

"The time is getting pretty short," said the spider to the fly, "and before we know it the annual meeting will be on us."

So I invite you all, all members of the Hawaii Medical Association, to come to Hilo May 21-24 for our annual meeting of the Hawaii Medical Association. Hilo is a small town and any organization such as this must be considered a big affair in our ordinary lives, and so we say, "Come to the fair!"

The weather is going to be beautiful, for the rain will all have been dumped on Kauai, Oahu, and Maui; the golf greens will be at their greenest and plushiest; the beverages, both alcoholic and nonalcoholic, will be at their driest best; the volcanic tilt continues at the present time and we expect a real bang-up volcanic eruption; and the Scientific Program? We have a fine one, I assure you.

A word about our famed Hilo hospitality. About ten years ago, when the last HMA meeting was held in Hilo, the Hawaii County Medical Society organized and maintained a car pool and hospitality committee. But nobody took advantage of it, so we don't know for sure just how effective it would have been. This time we will have a similar group organized, and all we ask of you is to give us a try.

Before the spider can turn to the fly and say, "Well, it is all over," I urge you all to plan for the 113th HMA Annual Meeting; if you come to Hilo, you'll enjoy our well-known hospitality. This I promise you.

Robert W. Meyerowitz

A Four-Year School—by 1974?

Our two-year medical school at the University of Hawaii is a going concern, but it cannot satisfy the real need, which is for a full four-year program. The entire sophomore class came to the February meeting of the Honolulu County Medical Society to convey this message. Surely this can't have happened often before, in the history of American medicine!

Well, we all knew a four-year school was in the offing, but what's so urgent about it? Several things—although it does seem that most of them could have been anticipated.

- The faculty in some clinical departments is just too small, in a two-year school, to provide the "critical mass" for discussion and optimal expertise.

- Research efforts cannot be adequate when faculty groups are so small.

- Students in a two-year school are too few to engage the services of a volunteer clinical faculty to the degree that they are available.

- The top-notch candidates for medical school don't often select a two-year school, no matter how good, in preference to a four-year school.

- The problem of transfer to a four-year school in the junior year creates worries that could be avoided.

- Not all scholarships are available to students in a two-year program.

- Whose alumni will the graduates be? Carol Brown, one of our sophomores, said "We'll be alumni of the school we graduate from—but home is where the heart is!" She got applause—but alumni support is important.

- And finally, Federal support for research is more available to a four-year school than to a two-year one; an application from our school was just recently rejected on this specific ground.

An application for a Special Improvement Grant, now pending, may permit the University to go ahead with plans to admit a third-year class in 1971 and a fourth-year class in 1972. Meanwhile, all possible backing at the State level needs to be mustered as soon as possible. Our officially professed support for the program, expressed in 1967 by a resolution, needs to be backed up by continuing support for the extra costs that will be involved—half a million dollars a year, or near it, for the next three years.

National Commission on Product Safety

Are household products contributing to the incidence of accidental injuries? And if so, how much?

Hawaii's physicians, along with physicians in the other 49 states, are being asked to tabulate their experience in this regard during the first two weeks of April.

The questions are being asked by Dr. Samuel C. Southard, a New Jersey pediatrician who is taking a year's leave of absence from his practice to serve on the National Commission on Product Safety.

You are urged to cooperate with him in this effort to assess the magnitude and nature of the problem of home accidents.

Insect Sprays Harm People!

The high incidence of asthma, hay fever, and other respiratory disorders on Oahu uncovered by our thorough survey in 1964¹ has gone unexplained, up to now. Weiner and Worth, in this issue of the JOURNAL, have documented a close correlation between this high incidence and the use of insect sprays—and even the amount of such use, within broad limits.

It is obvious that insects, being a year-round problem in Hawaii, are apt to be a matter of concern to housewives here for more months of the year than would be the case on the mainland. Does this result in greater use of insect sprays?

Safeway Stores, a chain of supermarkets which operates in 27 states and in Hawaii, provides a means of testing this hypothesis. If we do use substantially larger amounts of insect sprays in Hawaii, they ought to know it.

¹ Bruyere, P. T., Bennett, C. G., and Scott, A. A.: Oahu Health Surveillance Project, HAWAII MED. J. 24:436 (July-Aug.) 1965.

Well, they *do* know it—and the answer is that we do use more; at least, we *buy* more—twice as much! The ratio of insect spray sales to total sales in Hawaii's Safeway stores is approximately double that on the mainland.

This is a serious matter, deserving of serious attention. A business so lucrative cannot easily be cut down. The consumers must be made aware of the hazards to their health imposed by the use of sprays, and it should help if they can also be made aware of the relative ineffectiveness of sprays as an approach to insect control—especially for cockroaches and ants. Advertising quality control could help enormously, but this is a hopelessly unrealistic wish.

Physicians treating patients with asthma and other respiratory disorders can be of great help in educating the public, if they will explicitly warn their patients against the use of such sprays in the home.

Help Your Blood Bank Help You!

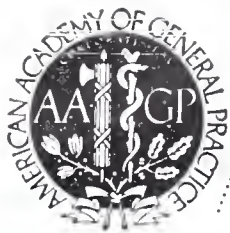
Honolulu has one of the oldest and best blood banks in the country, but it needs your help in recruiting more donors. In our affluent and heavily insured society there is a tendency for patients to just pay for blood they need, instead of replacing it by a donation. This is hard on the Blood Bank—but since it is competently and efficiently operated, by physicians and technologists who take pride in their work, you don't hear many complaints from them.

Over half the total supply, at present, does come from relatives and friends donating for a specific patient, to replace blood he has used. But nearly half still has to come from selected professional or semiprofessional donors.

A processed pint of blood costs a patient \$30.00, and a \$12.00 credit is applied to a patient's account for each donor he furnishes: five donors will pay for two whole processed units used.

The Blood Bank suggests that surgeons urge each patient scheduled for major surgery to find two volunteers to donate blood toward his account. They can make the donation, to be credited to the patient, at almost any blood bank in the United States: there is a national clearing house for this purpose. Donors must be between 18 and 59, must weigh at least 110 pounds, and must not have, or have had, malaria, jaundice, syphilis, tuberculosis, or epilepsy; must not have currently a cold, asthma, hay fever, other allergy or any infection. "Recent" medication, hospitalization, tooth extraction, injections of anything, or fresh tattoos make you ineligible for a week to six months, but not permanently.

Do please cooperate by urging patients to find volunteer donors before the need arises. The Blood Bank needs your help! ■



Hawaii Academy of General Practice

... the doctor has his hand in my pocket!

The cost of medical care is often in the headlines these days. Usually, their impact is another black eye on the image of the medical profession. The percentage of rise of this cost is compared with a lesser percentage in the over-all, or with a lesser rise in other areas of living.

Hardly ever is there a decent explanation given in the news media for this apparent "runaway escalation," this obvious "gouging" by physicians who "just know they are in short supply, and are taking advantage of whatever the market will bear."

Let us enumerate simply the reasons for these rising costs.

- The prime factor is the growing demand by the consumer;

- The increasing prevalence of insurance coverage is a large vector in the direction of increasing this demand by the consumer;

- The fairly sudden onset of quite comprehensive coverage by Medicare and Medicaid of a sizable segment of the population is another large vector pointing in the same direction;

- The sophistication of modern medicine is expensive in cost, and though saving in time, work, and even life itself, it is talked about as a "right" and not a privilege; and, lastly,

- The overhead of both physician and hospital has risen sharply. These truths should be self-evident and incontrovertible.

Mr. John Q. Public shops carefully for the staples of life. His wife compares sizes and brands, watches for loss leaders and bargain sales, even to the point of driving costly miles to save a few cents. John weighs the pros and cons carefully before choosing himself a car; Mr. & Mrs. go through all kinds of credit rituals before they are permitted to build or buy a home, considerations for which are the fatness of the pocketbook and the size of the paycheck.

But when John is sick? All that pecuniary interest flies out the window. How often does the patient appraise the cost before he undertakes a

choice of treatments? Almost never. He never even asks, or, if he does, the doctor gives him rather vague answers. The physician's office is the one place where necessities are considered but costs are not, by and large. True as this may be, however, it is not necessarily reprehensible. The necessities do indeed come first; the physician's concentration at the moment is on the patient's personal problem, his medical problem. The patient himself expresses little concern for costs; he often voices the phrase: "Hang the cost, Doc. Do what you think is necessary."

Alas! Comes the day of reckoning. Like the famous story of the Pied Piper of Hamelin, once the "emergency" is resolved and the patient is recovering, his postictal depression is compounded when he reaches into his pants pocket and finds that the doctor's hand is already there and filching the filthy lucre therefrom. This figure of speech is uncomfortably close to fact.

It is in the hospital that the physician tends to lose all sense of restraint, we must admit. He takes the "hang the cost" injunction rather too literally, and diagnostic procedures are often ordered like a boy shaking a whole tree just to get at one ripe mango.

We physicians cannot wholly deny complicity by some of us who, indeed, do tend to up our charges in the presence of high demand for, and scarcity of, medical services. Such are the exceptions; however, they tarnish our image nonetheless. Adherence to fee schedules, the element of professional competition in urban areas, and the reluctance of rural physicians to harass their patient-friends, the brakes applied by insurance limits, all these tend to keep the lid on physicians' fees. In fact, it is the essential conservatism of the practitioners of the healing arts, most of whom wish they could keep the dollar out of a relationship that is so very personal, that is one large reason why medical costs have risen only just lately. This rise is a "catching up"—another big reason in explanation of why it is unfavorably compared with the over-all increase in cost of living. ■

J. I. FREDERICK REPPUN, M.D.

Oral Contraceptives and the Urethra

With everyone knocking the "pill" nowadays—it's being blamed for everything from migraine to 5 o'clock shadow—it is refreshing to learn that it might be useful for something beside suppressing aene, or encouraging teenage promiseuity. Urologist R. M. Jameson (*Lancet*, February 1, 1969, p. 256) studied some 200 women of child-bearing age with a "urethral syndrome" comprising intermittent frequency and dysuria without evidence of underlying infection, chemical irritation, or urinary tract abnormality. In a small number of these patients, all urinary symptoms disappeared when they began taking oral contraceptives, particularly those preparations with high estrogenic activity. This probably represents a specific action of estrogens on the trigone and urethra.

Not all women will be helped by estrogens, but they seem worth trying, especially in those patients who develop intermittent urinary symptoms for only a few days preceding each menstruation.

Ski Hawaii and Die?

There appears to be continuing interest in the development of Mauna Kea and Mauna Loa on the Big Island as mountain sport and recreation areas—I have even seen an occasional bumper sticker around Honolulu, exhorting everyone to "Ski Hawaii." Most visitors and many kamaainas think of Hawaii in terms of ocean and beach, failing to appreciate the potential hazards of strenuous physical exertion at these altitudes (Mauna Kea is 13,796 feet).

A recent paper (*New England J. Med.*, January 23, 1969, p. 175) reemphasizes the problem of acute mountain sickness as experienced by a large group of soldiers in the Himalayas. Interestingly, there was no correlation between the altitude and the severity of attacks, severe attacks being seen as low as 11,000 feet. The time lag between arrival at altitude and the development of overt symptoms could be as short as six hours. During this prodromal period, predisposed persons were observed to develop irregular breathing, pulmonary congestion, and a decrease in urinary output. When mountain sickness developed, frequent symptoms were headache, nausea, anorexia, dyspnea, weakness, chest pain, giddiness, and

vomiting. Objective findings were pulmonary edema, papilledema, and, in two fatal cases, cerebral edema. The most effective treatment was diuresis with Furosemide, occasionally supplemented by morphine and steroids.

This article documents the hazards of activity at altitude, particularly when there has been insufficient time for acclimatization as would occur in Hawaii. An early warning of impending trouble is a decrease in urinary output, which raises the possibility of prophylactic administration of diuretics prior to mountaineering ventures. Despite possible social embarrassment in mixed parties, this simple measure may well avert a life-threatening catastrophe.

Memo to Medical Researchers

Many years ago, Sir Robert Hutchinson said it all when he prayed: "From inability to let well alone; from too much zeal for the new, and contempt for what is old; from putting knowledge before wisdom, Science before Art, and cleverness before common sense; from treating patients as cases; and from making the cure of the disease more grievous than the endurance of the same, good Lord, deliver us."

To which one can only add a fervent "Amen."

Chromosomes and Criminals

The interest of the medicolegal world has recently been revived in a possible link between chromosomal abnormalities and criminal behaviour. Most attention has been focused on males with an extra Y chromosome, the XYY syndrome. Genetic surveys of prison populations have revealed an unusually large number of inmates who have committed violent crimes and have the XYY syndrome. These prisoners seem to have one typical physical characteristic: above-average height. Their personalities are unusual in that they are prone to impulsive, violent, uncontrolled, anti-social behavior. Following these outbursts, they suffer great remorse and feelings of guilt.

At the present time these criminals are still medical curiosities as there are insufficient genetic data available to conclusively correlate chromosomal aberrations with personality disorders. Still, next time you are called to see a berserk basketball player, remember he may be an XYY. ■

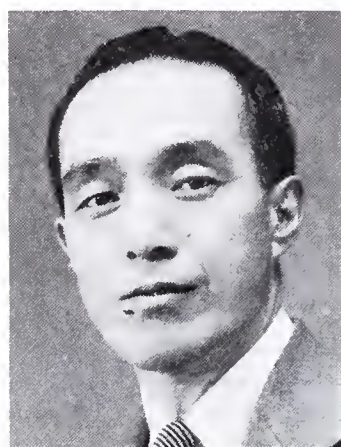
W. PHILIP JONES, M.D.

This is the seventy-seventh installment of In Memoriam—Doctors of Hawaii.

Motokazu Mori

Dr. Motokazu Mori was born July 24, 1890, in Nagasaki, Japan, son of Dr. and Mrs. Iga Mori.

He was educated at Daiichi-chu Gafu and Daiichi-Kotogakko in Tokyo and at Kyushu Imperial University in Kyushu where he received his M.D. degree in 1916. He then specialized in surgery. In 1918 he came to Hawaii and later went to Mayo Clinic for further study. Dr. Mori returned to Honolulu in 1920 when he was licensed to practice and became associated with his father, Dr. Iga Mori.



DR. MORI

In 1936 he was awarded a doctor of medical science degree from Tokyo Imperial University for his study of the change in blood composition in second generation Japanese due to climatic changes.

Dr. Mori served as president of the hospital staff at Kuakini Hospital and was a staff member at Queen's, St. Francis, and Kapiolani Maternity hospitals until 1941, just before World War II. He was a member of the Honolulu County Medical Society and the Pan-Pacific Surgical Society.

On October 17, 1921, in Honolulu Dr. Mori married Miss Misao Harada, daughter of Dr. and Mrs. Tasuku Harada, Professor of Oriental Languages at the University of Hawaii. They had four children: Arthur K., graduate of Yale Law School and practicing in Tokyo; Victor M., graduate of Temple University School of Medicine; Margaret (Mrs. Stanley Hirozawa), a graduate of the University of Hawaii now married and living in Trenton, Michigan; and Felix, deceased.

His wife died on August 16, 1927, and on April 19, 1930, the doctor married Dr. Ishiko Shibuya in Honolulu. She had received her medical degree from Women's Medical College in

Tokyo. During the second World War, they were both interned in Texas for four years and were able to do some professional work among those interned with them. When he returned in 1945, Dr. Mori again became a member of the staff of Kuakini Hospital.

Dr. and Mrs. Mori had two children: a daughter, who died, and one son, Ramsay, now working for United Air Lines.

Dr. Mori died in Honolulu, Hawaii, on January 21, 1958.

The doctor was a cultural leader among the Japanese people in Hawaii and was himself a poet and interested in philosophy and art. Dr. Mori was a Christian.

George Bass Tuttle

George Bass Tuttle was born in Boone County, Missouri, July 21, 1871, the son of Samuel M. and Sallie A. (Bass) Tuttle.

His M.D. was earned at Washington University, St. Louis, Missouri, in 1894. Dr. Tuttle interned from 1894 to 1896 at the Insane Asylum at St. Louis, the hospital for the Soldiers' and Sailors' Home in Quincy, Illinois, and the Female Hospital in St. Louis.

He entered the U.S. Army in 1901 as a contract surgeon, and in 1908 he became a 1st lieutenant in the Medical Reserve Corps. He saw service in the Philippines, the United States, and Hawaii. Stationed at Ft. DeRussy on Oahu in 1912, he took his Territorial medical examination and was licensed to practice in July of that year. The following month he retired from the Army, was appointed government physician for the Koolauloa and Koolaupoko district, and settled at Heeia.

On October 29, 1903, Dr. Tuttle married Miss Evelyn L. Blood in Manila. One son, Lawrence S., was born to the Tuttles.

After six years at Heeia, the doctor moved to Waimea, Kauai, where he engaged in private practice. In 1928 he moved to Kaunakakai, Molokai, where he was a government physician, and the following year he became assistant physician at Kalaupapa. On the resignation of Dr. Lorenzo F. Luckie in December, 1934, Dr. Tuttle was appointed acting resident physician of the Leper Settlement. Retiring from active practice in June, 1939, Dr. Tuttle left Kalaupapa and moved to

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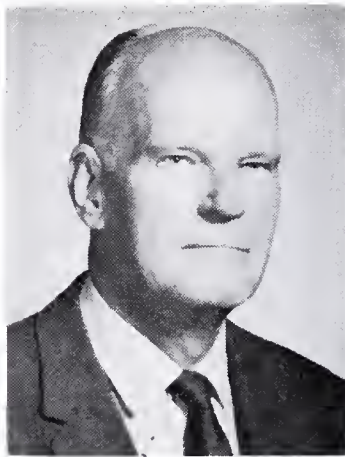
- While at a carnival this 14-year-old boy passed black stools without pain or forewarning. The massive gastrointestinal hemorrhage required transfusion.
- General health had been good except for the usual childhood illnesses and allergy. No history of indigestion or trauma.
- Upper gastrointestinal series showed a normal appearing esophagus, stomach, and duodenum. Notwithstanding, the patient was placed on an ulcer therapy regimen.
- Another incapacitating intestinal hemorrhage occurred three weeks later without prodromal symptoms.
- This follow-up small bowel roentgenogram reveals the source of bleeding.
- What is your diagnosis?
- Answer is below.

Note the large oval collection of barium in the right lower abdomen. A preoperative diagnosis of Meckel's diverticulum was made and surgery advised. A tennis-ball-size Meckel's diverticulum was resected which contained ectopic gastric mucosa, acid-producing parietal cells, and deep peptic ulceration. Recovery was uneventful.

Submitted by the
RADIOLOGICAL SOCIETY OF HAWAII
ROBERT G. RIGLER, M.D. ■



Charles F. Aquadro, M.D.
311 Iliaina Street
Kailua, Hawaii 96734
**GENERAL & UNDERWATER
MEDICINE**
University of Tennessee School of
Medicine—1952
Internship—U. S. Naval Hospital,
Oakland, California—1953-1954



Frank P. Mathews, M.D.
Waimea Clinic
Waimea, Kauai 96796
INTERNAL MEDICINE
Harvard Medical School—1930
Internship—St. Luke's Hospital,
New York—1930-1932
Residency—Grace New Haven
Hospital—1946-1947
The Queen's Hospital, Honolulu—
1961-1962



Lorene M. Anastasi, M.D.
839 South Beretania Street
Honolulu, Hawaii 96813
OPHTHALMOLOGY
Creighton University—1963
Internship—Long Beach
Memorial—1963-1964
Residency—Mayo Clinic—1964-1968



Casper F. Rea, M.D.
Waimea Clinic
Waimea, Kauai 96796
SURGERY
USC—Los Angeles—1951
Internship—Orange County General
Hospital—1951-1952
Residency—Veterans Administration
Hospital
Albuquerque, New Mexico—
1952-1956
Veterans Administration Hospital
Brooklyn, New York—1958-1960



Tsuyoshi Yamashita, M.D.
1697 Ala Moana Blvd.
Honolulu, Hawaii 96815
OPHTHALMOLOGY
Juntendo Medical College—
Tokyo, Japan—1950
Internship—Tokyo University
Hospital—1950-1951
Juntendo University Hospital—
1951-1952
U. S. Tokyo Army Hospital—
1952-1953
Residency—St. Louis City Hospital—
1953-1955
Boston City Hospital—1955-1966



Albert P. Ley, M.D.
3420 Kuhio Highway
Lihue, Kauai 96766
OPHTHALMOLOGY
Harvard Medical School—1943
Internship—Denver General
Hospital—1944
Residency—Barnes Hospital,
St. Louis, Mo.—1954-1958

Honolulu

Approximately 225 members attended the annual meeting held on December 10. The proposed Bylaws changes were adopted as circulated with one change: the amendment changing the age from 65 to 70 for life members was deleted. The Chair announced that the 1969 dues would remain at \$80. It was voted to accept the annual reports as circulated. Mrs. George Schnack, outgoing President of the Woman's Auxiliary, spoke briefly of the Auxiliary activities and presented the new president, Mrs. Donald Jones, who introduced the other officers. Dr. K. S. Tom presented outgoing president, Herbert Chinn, with a plaque in recognition of his leadership. The Sing Out Hawaii group entertained the membership while the ballots were being counted.

Andrew Morgan, Chief Teller, announced the results of the election as follows:

President: K. S. Tom

President-elect: Richard S. Omura

Secretary: Thomas P. Frissell

Treasurer: Winfred Y. Lee

Board of Governors: Charles T. H. Ching, Francis T. Oda, Leslie A. Vasconcellos, Coolidge S. Wakai, and Livingston M. F. Wong

Alternate Board of Governors: Douglas B. Bell, II, Max Botticelli, Hing Hua Chun, and Niall M. Scully

Board of Censors: Herbert Y. H. Chinn

Nominating Committee: Albert Chun Hoon, Glenn M. Kokame, Noboru Ogami

Delegates to HMA: Douglas B. Bell, II, Ann B. Catts, Albert Chun Hoon, William W. K. Dang, Thomas P. Frissell, George Goto, Reginald C. S. Ho, Michael M. Okihiro, Livingston M. F. Wong

Alternate Delegates to HMA: John C. Carson, Max Botticelli, Winfred Y. K. Chang, George M. Ewing, John A. Krieger, Carl E. Johnsen, Harold G. Lawson, Alvin A. C. Paraz, Alfred D. Morris, Frances F. Nakamura, Catalino C. Cachero, Robert Oishi, Walter H. K. Watt, Francis Fukunaga, Robert A. Nordyke, Clifford Straehley, Clifford B. G. Chang, Kenneth Chinn, Philip T. Chu

Dr. O. D. Pinkerton conducted the installation of the new officers which was followed by an address given by the new president, K. S. Tom.

Hawaii

The June 20 meeting was held at the Tropics Lanai. Dr. Jones reported on the recent HMA meeting and advised that the 1969 meeting would be held in Hilo if the Naniloa completes its convention facilities by that time. The Honokaa problem of getting drugs at the prices in effect prior to the arrangement of having them ordered by a Hilo pharmacist was referred to Mr. Frank Kiefer. The meeting ended with a talk by Mr. Richard P. Bergen of the AMA who advised of the services and functions of their Legal Research Department.

The July 25 meeting was held at the Tropics Lanai. A discussion of AMA-ERF was tabled pending further consultation with Dr. Bracher, committee chairman. Drs. Okumoto and Carvalho were appointed to contact Mr. Robert Buffet to discuss problems concerning the legal and medical professions. A County Review Committee was established with the appointment of the fol-

lowing members: Drs. Adams, Tabrah, Mitchell, Oakley, and Belcher (chairman). It was noted that no review had been made of the statistics gathered by the tumor registry. Dr. Wippermann volunteered to contact Dr. Woo in order to establish a tumor committee. The meeting concluded with a talk by Dr. Ted Rowe on his experiences in the Trust Territories as a medical officer.

At the August 16 meeting it was suggested that a Society meeting be held in one of the outlying districts. A letter from Dr. Kleona Rigney was read in which the continued support of the Hawaii County Medical Society in diabetic screening was solicited. Drs. Shim and Baker spoke on "Diagnosis and Treatment of Alimentary Tract Lesions in the Newborn."

A discussion on uniform licensing took place at the October 3 meeting. The Cancer Society's letter urging all members to join in the oral cancer program was read. Dr. Okumoto reported that he had contacted Mr. Bethea. It was voted to schedule a meeting sometime in 1968 or 1969 without wives. A vote of thanks was extended to Dr. Mizuire for his donation of 100 medical texts to the Fred Irwin Library. Approval of special licensing of Dr. DeWitt Smith to practice in the Hilo Medical Group was voted. It was voted to petition the Legislative Committee of HMA to seek legislation permitting medical corporations to be formed in Hawaii. Drs. Best, Carvalho, and Crawford were appointed to the Nominating Committee. The meeting concluded with a talk by Dr. Andrew Gage on "Treatment of Neoplastic Diseases Using Cryotherapy."

Kauai

Eleven members were present at the January 7 meeting. A committee was appointed to look into the scheduling of less frequent meetings. It was voted to amend the Bylaws to provide for four meetings a year plus special meetings to be called by the President or on the request of three members. It was also voted to amend the Bylaws to provide for an Executive Committee. The two Bylaw changes will be held over until the next meeting. A bill from the Poipu Hotel for an RMP dinner was noted and it was suggested that this bill be sent to RMP. Further clarification of RMP projects will be discussed at future meetings. Dr. W. McLaughlin was accepted as a new member of the Society. It was voted to send five students to Honolulu to participate in Careers Day.

The February 4 meeting was held at the Kauai Veterans Memorial Hospital. Dr. Miyashiro reported on the January meeting of the HMA Council. After a review of the financial report, it was voted that a special \$20 assessment be made for 1969. The two changes in the Bylaws laid over from the last meeting were passed. Dr. E. Rames was appointed as an advisor for the practical nursing course being offered by the Kauai Community College. It was voted to invite the President and President-Elect of the HMA to a dinner meeting in April, the place to be decided by the Executive Committee.

Maui

The January 21 meeting was held at the Maui Frontier Hotel. It was voted to appoint Drs. Haling and Uehara

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**Modern Nutrition in Health and Disease
(Dietotherapy), 4th Ed.**

By Michael G. Wohl, M.D., and Robert S. Goodhart, M.D., D.M.S., 1240 pp., \$30.00, Lea & Febiger, 1968.

THE RAPID GROWTH of the nutritional sciences and the many advances in this field have made it necessary to update this well-known textbook. Like its predecessors, the fourth edition continues to be presented in three major parts: Normal Nutrition; Nutrition in Disease; and Nutrition in Periods of Physiologic Stress. There has been improvement in format and typefaces, as well as the addition of three new chapters.

Most of the 43 chapters are excellent; a few are mediocre. Most clinical and research specialists may find that chapters within their provinces are relatively superficial surveys, but this is true for most textbooks that cover the various subspecialties.

The first 19 chapters review pertinent normal physiology and biochemistry, with a tendency to present facts and data without expanding on mechanisms. For example, in chapter one, the authors quote the paper of Thomson *et al* stating that "weight loss tends to decrease as the duration of caloric restriction increases," but there is no discussion as to the probable mechanisms involved. Despite this weakness, the first chapter covering Body Weight, Body Composition, and Calorie Status is done especially well by Keys and Grande. It provides basic physiology for the physician who undertakes the problem of obesity and weight reduction.

As usual, Levine presents the section on carbohydrate metabolism skillfully. It could have profited by the addition of more of the recent references.

The section on fluids and electrolytes is especially weak, and it is surprising that sodium and potassium are discussed so superficially, for whenever diet is a factor in the treatment of disease, sodium metabolism is bound to enter the picture.

Dietotherapy of Diabetes also includes a discussion of hyperlipidemic states, and is a welcome addition to the approach of evaluating the interrelationship of carbohydrate and lipid in the induction of hyperlipidemia.

This book should serve as a comprehensive reference and guide to further reading on virtually any aspect of diet and nutrition, in health and disease. The size (1,240 pages) and cost (\$30.00) of the book will probably place this book in the reference category, and many physicians may prefer shorter and less costly guides to diet therapy.

WILLARD Y. MIYAHIRA, M.D.

**The Principles and Practice of Medicine,
17th Ed.**

Edited by A. McGehee Harvey, M.D., D.Sc., (Hon.) Leighton E. Chuff, M.D., Richard J. Johns, M.D., Albert H. Owens, Jr., M.D., David Rabinowitz, M.D., and Richard S. Ross, M.D., 1,472 pp., \$22.50, Appleton-Century-Crofts, 1968.

SIX EDITORS and 59 contributors, all of the Johns Hopkins University School of Medicine, either former or present, conceived this as a Johns Hopkins text book of medicine, as proposed by Osler. It attempts to present clinical problems rather than disease entities as such, and how such problems are handled by the experienced physician. In my opinion it succeeds very well.

★ means highly recommended.

The book is divided into 19 sections, starting with "The Approach to the Patient," "Disorders of Water and Electrolyte Metabolism," and finishing with a short section on "Ocular and Cutaneous Manifestations of Disease." The book is heavily larded with tables of differential diagnoses which I like but which, I am afraid, tend to oversimplify in many cases.

Well written and easily read, this volume will make a good addition to any doctor's library.

W. H. SAGE, M.D.

Adolescents in a Mental Hospital

By Ernest Hartmann, M.D., Betty Ann Glasser, M.S., Milton Greenblatt, M.D., Maida H. Solomon, B.A., B.S., Daniel J. Levinson, Ph.D., 197 pp., \$2.75, Grune & Stratton, 1968.

THIS STUDY OF A COHORT of 55 adolescents admitted to the Massachusetts Mental Health Center over a two-year period is most striking for the data relating to the outcome following hospitalization with information regarding six-month, one-year, and five-year follow-up studies. Discussion of possible prognostic factors is important for all who work with seriously disturbed adolescents. This thoughtful work begins with a brief resumé of some of the pertinent literature, and moves on to a discussion of the characteristics of the cohort and the problems and issues produced by hospitalization. There is an especially good description and analysis of a group composed of parents of the hospitalized adolescents. A point made by the authors is that adolescents do as well when mixed with adult patients in a general psychiatric hospital as when treated in special adolescent units. This is especially relevant for those who have to plan for mental health care.

KWONG YEN LUM, M.D.

★Immunohematology

By Chester M. Zmijewski, Ph.D., with the assistance of June L. Fletcher, B.S., M.T., (A.S.C.P.), B.B., and Ronald L. St. Pierre, Ph.D., 300 pp., \$13.75, Appleton-Century-Crofts, 1968.

STUDENTS WISHING TO ACQUIRE basic, working knowledge of immunology of blood group antigen systems need this book. It is written in concise and understandable fashion, with numerous excellent explanatory illustrations. There are some references. Although this is a small volume, it is an excellent introduction to the complex subject of the immunohematology of the blood group systems.

ROBERT T. S. JIM, M.D.

Clinical Hypnotherapy

By David B. Cheek, M.D., and Leslie M. LeCron, B.A., 245 pp., \$7.50, Grune & Stratton, 1968.

A CONCISE AND READABLE book written primarily for those who are unfamiliar with hypnosis and its techniques. However, hypnotherapists who are unfamiliar with the work of LeCron and Cheek will find their approach to hypnotherapy refreshing. The application of hypnosis to a gamut of problems, both physical and psychological, is discussed briefly but helpfully. ■

KWONG YEN LUM, M.D.

COUNCIL MEETING

**Oahu Country Club
January 22, 1969—6:00 P.M.**

PRESENT

Robert M. Miyamoto, presiding, Drs. Batten, Chinn, Fong, Iaconetti, Jones, Lowrey, Mills, Miyashiro, Moore, Richardson, and Sloan, plus Drs. Goto, Lee, Stephenson, Sowers, B. C. K. Tom, Wakai, Morris, K. S. Tom, Oren, Frissell, Nordyke, H. H. Chun, and Mytinger, Messrs. Richard Layton, H. Tom Thorson, and V. Thomas Rice.

MINUTES

The minutes of the October 23, 1969, meeting were approved as published in the Nov.-Dec. issue of the JOURNAL.

COMMUNICATIONS NOT REQUIRING ACTION

Letter from Aetna Life & Casualty Insurance Co.: A letter from Aetna relative to Medicare payments to plantations was circulated and reviewed by the Council. It was pointed out that a subcommittee was appointed to meet with representatives of industry to discuss plantation medicine. Industry was approached several times but no meeting materialized.

As a point of information, the Council was informed that since Honokaa is without a physician, the plantation has employed a Kaiser physician. However, Dr. Jones stated that the physician hired intends to terminate his services with Kaiser. It was also noted that Straub Clinic was approached by industry to cover this area on the Island of Hawaii and also has been approached by a physician on Lanai. Straub has studied the matter and disapproved the proposal by the plantation but is still considering the proposal by the physician on Lanai.

ACTION:

It was voted to accept the letter from Aetna as circulated and to place it on file.

COMMUNICATIONS REQUIRING ACTION

Letter from Dr. West: A letter from Dr. West relative to HMA's relationship with the National Center for Health Services Research and Development was circulated. The director of this Center is Dr. Paul J. Sanazaro. Dr. Mytinger stated that the School of Public Health at the University of Hawaii is attempting to get Hawaii named as one of the Health Services Research Centers in the United States for such a project. They would like to have the doctors of the State become involved in a project with the National Center for Health Services Research and Development. It was noted that the HMA's Bureau of Planning and Research is working on Dr. Sanazaro's report on the quality of medical care in Hawaii and that these two bodies (Bureau of Planning & Research and School of Public Health) should get together since there may be a close similarity in their goals. Dr. Mytinger stated that the Center must be placed in some nonprofit entity.

ACTION:

It was voted to refer Dr. West's letter to the Bureau of Planning and Research to explore

and to prepare an answer for the members of the Council.

Letter from Dr. Worth: A letter from Dr. Robert M. Worth, M.D., Ph.D., Professor of Public Health, Associate Dean for Academic Affairs of the University of Hawaii, stated that Dr. Richard K. C. Lee, Dean of the School of Public Health, announced his retirement from that post as of March 1, 1969. Dr. Worth invited the HMA to nominate anyone it feels would be appropriate as Dean of the School of Public Health.

ACTION:

It was voted that the HMA staff circularize the entire membership about the opening of this position.

It was suggested that the President of the HMA write a letter of thanks to Dr. Worth for informing the HMA on his matter.

Letter from American Cancer Society, Hawaii Division: A letter from the Cancer Society relative to endorsement of promotion of checkups was circulated and noted.

ACTION:

It was voted to endorse the principle of the letter even though there is objection to the wording of the letter.

Letter from AMPAC: A letter from AMPAC relative to scholarships was circulated and reviewed. HMA was invited to suggest interested members of the staff or other medically oriented individuals as recipients of a fellowship. Dr. Mills pointed out that there is a registered nurse who might be interested in applying. Dr. Mills was advised to make application as soon as possible.

Letter from The Arthritis Foundation: A letter from The Arthritis Foundation requesting endorsement of workshop lectures to be held on the neighbor islands and rural Oahu was circulated and discussed.

ACTION:

It was voted that The Arthritis Foundation be informed that the HMA endorses their program.

Letter from Mr. Albert Yuen of HMSA: A communication from HMSA requesting an informal discussion of seeking ways and means to curb or level off the rising costs of medical care was circulated. There was considerable discussion and some felt the physicians should meet with representatives of the Employers Council, organized labor unions, and insurance. Other Council members felt that the physicians should meet with HMSA first to see what they have in mind. Some members of the Council expressed disappointment that the letter was not written by one of HMSA's medical directors.

ACTION:

It was voted that an appropriate day in February be selected to meet with Mr. Yuen of HMSA, representatives of the insurance industry, Employers Council, and organized labor unions to discuss medical care cost in Hawaii.

REPORT OF THE SECRETARY

The Secretary's report was presented and discussed.

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Professional Moves

The din of a thousand firecrackers and the sight of gyrating dragons chasing the evil spirits away in Chinatown reminds us that the Year of the Rooster is with us. We herewith offer our humble blessings to those starting anew. Cardiologist **Ed Chesne** left the Straub Clinic for Harkness Pavilion, Queen's Medical Center, thus joining the new breed of physicians who prefer to practice on the premises of a hospital. Internist-oncologist **John Keenan**, who directs the Queen Emma Project, has also relocated to Harkness Pavilion from the Pali Medical Building. Where John left, neurosurgeons **William Won** and **Calvin Kam** moved in and established the Hawaii Neurologic Clinic. **Charles Aquadro**, who does general practice and underwater medicine, opened his office at Kailua Professional Center. On the Big Island, **DeWitt Smith**, from Princeton, associated with the Hilo Medical Group at 305 Wailuku Drive and **Richel Khoury**, who does both pediatrics and internal medicine, associated with the Waimea Medical Center at Kamuela, Hawaii. May the Year of the Rooster bring everyone "crowing" success!

Elected, Appointed, Honored

We honestly feel that we can neither add nor detract from the *Honolulu Advertiser's* editorial on **Charley Judd** so we herein reprint it in toto: "With quiet dedication over the past three years, a Hawaii doctor has been demonstrating the best of his family heritage and what Hawaii should have to offer other Pacific islands. Dr. Charles Judd Jr. has completed work as a surgeon for the government of Western Samoa, a nation with growing social needs and few financial resources. Just by being a qualified surgeon on the scene, Judd performed a vital function in this young island nation. But it is clear he was far more than just another doctor in Samoa. He and his wife, Mary, enjoyed a special respect. Not only did he work 70 hour weeks in surgery; his sincerity and interest in Samoa and its people were evident and appreciated. A visitor to Apia would find Samoans saying things like: 'The Judds seem to understand us. . . . They are friends.' At a farewell ceremony in Apia last week, Western Samoan Minister of Health Luamanuvae Eti said to Judd and his family: 'Consider this country to be your country and this people your people. It is my sincere wish that some day we will receive an urgent message that you want to return home—to Samoa.'

"In a sense, Judd, who left a lucrative practice here, was following in a family tradition of service. His great-grandfather was Dr. Gerrit Judd, a medical missionary who came to Hawaii in 1828.

"Judd's work in Samoa has not been unappreciated in Hawaii. Earlier this year, the Hawaii Medical Association presented him with the Robins Community Service Award, naming him Hawaii's physician of the year.

"The citation said: 'This physician, soldier, medical historian, public servant, churchman, mountaineer, athlete, and specialist in Polynesia has left his mark on Hawaii.'

"Not everyone, will be able, as Judd did, to take a family off at real financial sacrifice to help people in another, more needy land. But his qualities of professional precision and personal gentleness have much to offer as an example of how Hawaii can best serve a useful and humanitarian role in the Pacific."

Another humanitarian who has been active in international goodwill is **John Holmes**, the new president of the United Nations Association, Hawaii division.

On the home front, **Daniel Whang**, who has been the Leilehua football team physician for the past 15 years, was one of three Wahiawa men honored with "Man of the Year" awards by the Wahiawa Community and Businessmen's Association.

We congratulate the newly-elected Fellows among Hawaii's specialists. **Philip J. W. Lee**, who was made a Fellow of the American College of Radiology. Fewer than 1,200 of the 7,000 members of the College have been awarded the degree of Fellow. **Hau N. Vu** will be installed as a Fellow of the American College of Obstetricians and Gynecologists at its annual meeting to be held April 28-May 1 in Bal Harbour, Florida. **Albert Kong** and **Rowlin Lichter** were recently inducted as Fellows of the American Academy of Orthopedic Surgeons in New York. We must add that Rowlin has written a series of eight humorous, readable articles with a conversational motif on orthopedic problems which will appear in a local newspaper; i.e., as soon as Bud Smyser remembers where he has misplaced them. . . .

On the political front, we note that **Ike Kawasaki** was appointed to the Civil Defense Advisory Council, and **James Matayoshi** and **James Mitchell** were named County physicians by County Mayor Kimura. **David Katsuki** was reappointed City & County Physician, and **Tommy Chang**, newly appointed as Assistant City & County Physician by our new Honolulu Mayor, Frank Fasi.

The tongs have elected some of their new officers. Tongman **Bernard Fong**, last year's president of the Chung-Shan Benevolent Association, was appointed a trustee of the United Chinese Society. **Maria Brault** (of Sons of Italy fame) received the group charter of the Catholic Daughters of America at the first anniversary of their local court, "Aloha Malia." Our Alii **George Mills** of the Prince Kuhio Club was elected president of the Oahu District of the Association of Hawaiian Civic Clubs. Internist **Clagett Beck** was reelected Surgeon of the State Society of Colonial Wars.

On the charitable front, HMA president-elect **John Lowrey** was reelected director of the 1969 Aloha United Fund and RMP director **Masato Hasegawa** was reelected vice president at the organization's annual meeting. May their 1969 efforts be more fruitful. . . .

Members Speak Up

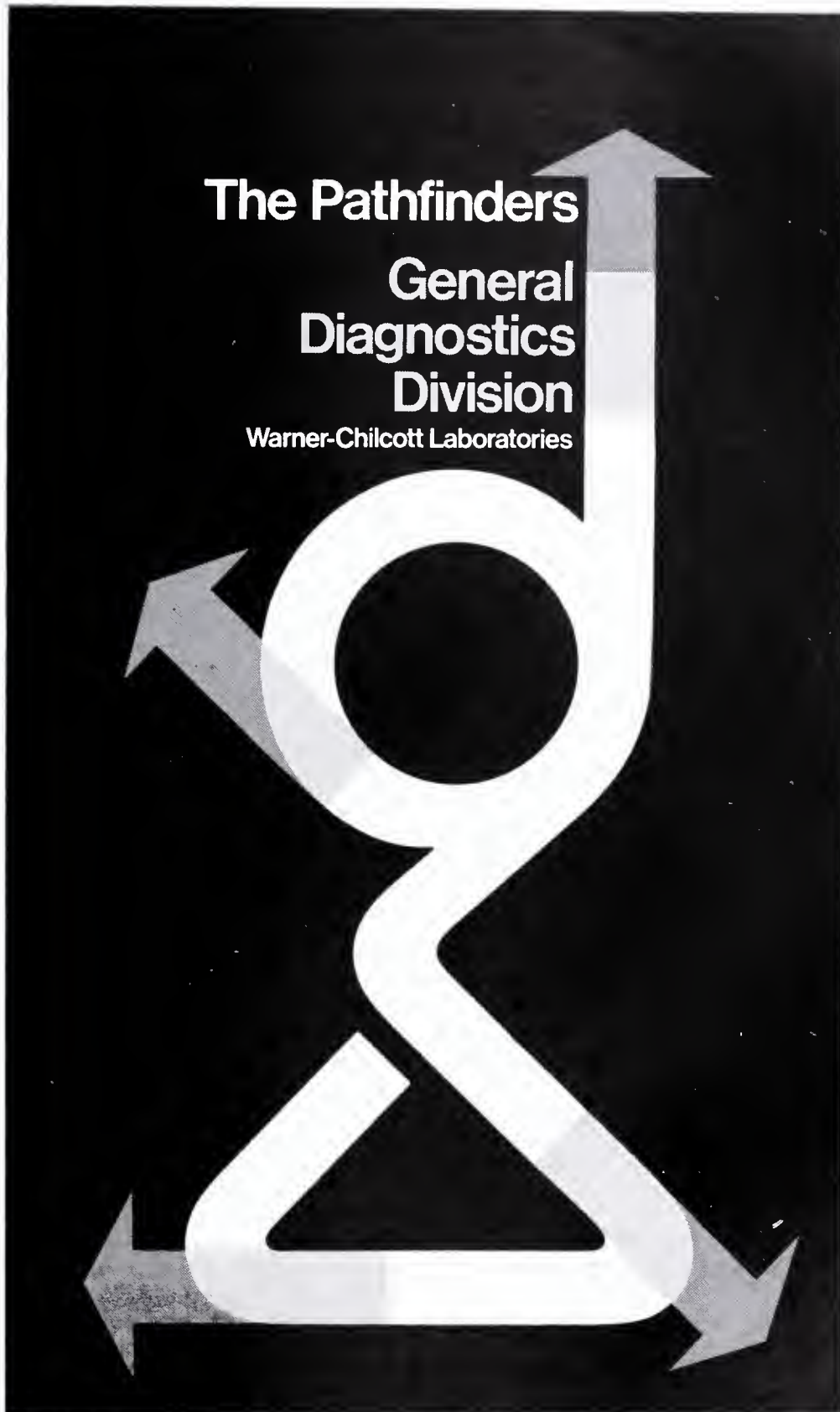
The laity somehow regard us as being practically omniscient. They freely solicit our opinions, and we freely proffer same. Perhaps we are merely satisfying our egos, or perhaps we are really doing some good in health education.

Back in November, a Honolulu dermatologist, who prefers to remain anonymous, admitted he was running a losing battle in his one-man campaign to prevent the sale of iodized salt in Hawaii because people simply prefer iodized salt to the noniodized variety. "It's simply not sensible. . . . It seems to me and to others that acne might be more common and severe in Hawaii at least partly because of the excess iodine." He feels that islanders using iodized salt are harming, more than helping themselves, because the soil and water here contain a lot of iodine naturally.

Duke Choy of the Committee of Responsibility spoke at the Honolulu Ministerial Union meeting and described

continued page 332

The Pathfinders
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HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: EDITH G. EKSTEIN, MT(ASCP), U. S. Army Tripler General Hospital

Maui in May

Both Honolulu and Lahaina will figure in this year's Annual Convention, according to information released by Rachel West, 1969 Convention Chairman. Plans are almost complete for the 20th annual get-together and the tentative program has been circulated.

The meeting will open on Thursday, May 15, at The Princess Kaiulani Hotel in Honolulu. A morning session will deal with coagulation factors and the afternoon speaker will present the first of two talks on the repair and maintenance of laboratory instruments. Registration, exhibits, luncheon, and dinner (and coffee breaks!) are all scheduled for opening day. The annual business meeting will be called to order at 8:00 P.M., at which time officers for 1969-70 will be elected.

On Friday, May 16, the scene will shift to The Royal Lahaina Hotel on Maui. This will be the first time the Hawaii Society has held a major meeting on any island but Oahu. No official activities will start until 3:00 P.M. By that time, presumably, the exhibitors will be back in operation and all of the city folk will have adjusted to the country air. The Model S. Coulter Counter, Rheumatic Diseases, Instant Thin Layer Chromatography, Advanced Hematology and Blood Banking, and Instrumentation will be the subjects presented on Friday and Saturday.

The usual festive banquet will serve as the finale of scheduled events on Saturday. Sunday will be a free day for those who wish to tour, swim, try Maui's fabled golf courses, or just plain loaf before returning home.

Final information regarding reservations, costs, prearranged tours, and golf reservations should be available from Mrs. West before or at about the time this issue is published.

Planning and Scope Committee Initial Report

This committee was appointed in 1965 and was given five years to study changes in ASMT which might require or suggest changes in HSMT, and to examine the existing goals and operations of HSMT and try to determine what modifications might seem desirable.

We have consulted with many members of the Society in the past three years and recommend that HSMT undertake programs of change in five general areas: (1) constitutional reform, (2) li-

censure legislation, (3) society publications, (4) educational programs, and (5) membership.

After preliminary talks, the Publications Committee took over planning in that field but, because of the overlap of personnel between the committees, their report will be submitted later as part of the Planning and Scope report.

Constitutional Reform. The committee feels that changes in the ASMT constitution should either suggest the desirability of or make the requirement that changes be made in our own constitution. Further, certain basic philosophies should be changed. To provide for the necessary alterations we suggest that this is a good time to rewrite the entire patched-up document.

At the present time our Constitution does not represent the interests of prospective members on the neighbor islands, and the effect of this, in part, is that we have almost no members from any island but Oahu. In reality, we have become an Oahu Society.

In order to become a true Hawaii Society, our Constitution will have to be changed to include, among others, these guarantees: (1) that dues to the state treasury be used for state programs (Christmas parties, picnics, and monthly meeting expenses would not qualify), (2) that important meetings be scheduled for definite times and well in advance (this would probably limit business meetings to one or two a year, and would make it impossible to run the Society without long-range plans), and (3) statewide meetings should be held on the various islands on a basis proportional to membership in each location, subject to modification by considerations of convenience, availability, and adequacy of facilities.

Several constitutional structures could serve our purposes. Some states have subdivided themselves into regions, some use branch societies and others use combinations of the two. We should make our choice after consulting with prospective members on the neighbor islands.

Whether or not we attract members from the other islands is not the main issue. It is much simpler: we must stop erecting barriers which keep us apart. No one would deny that every medical technologist in Hawaii should have the same opportunity to participate in HSMT deliberations and elections and to profit from HSMT programs. In all fairness these rights should be guaranteed by our constitution.

At the beginning of the current fiscal year, the Planning and Scope Committee promised to put this message into the form of a letter so that our

president could use it to approach potential members (see ASMT News Release on that subject) throughout the state. We believe that a copy of this report, when accepted, will serve. We so recommend. We further recommend that HSMT send its president or the chairman of its Constitution and Bylaws Committee, or both, to consult with medical technologists on the neighbor islands before recommending the type of Constitution we should write.

HSMT—Focus on the Future

Just after World War II, I was working in a hospital laboratory that was on a six-day work schedule. The shortage of personnel during the war had necessitated the change from a 40-hour week to a 48-hour one, and resulted in a 20 per cent differential for that extra eight hours. If you've ever worked a hard five-day week, try working a six-day one for months on end. When rumors flew that we would be cut back to a regular schedule, you couldn't have seen a happier crew. But with the written official notification of the change was also the low blow that we would also lose the pay differential. This was ridiculous! We were already the lowest-paid technologists in the area. So what did we do? We quit! It really wasn't an organized walk out. There were eight of us who had been planning moves anyway. We reasoned (and this turned out to be correct) that if we left at that particular time, we would really be helping those who were planning to stay. We would be forcing "someone" in the higher chain of command to take care of those who had really become attached to their jobs, had given long years of service, did not want to lose their seniority, or who had become enamoured of the geographical area. My point is this—we didn't even sit down and talk it over with those who held the purse-strings. We were completely unorganized. Although this incident did not happen in Hawaii, it could have, just as easily.

I can't imagine anything like that occurring here now. My confidence stems from long association with HSMT and watching its growth and maturity. Like most societies, ours was organized to fulfill our many needs—the need to gain more knowledge, the need to compare and improve methods, the need to coordinate teaching and teaching methods, as well as social and welfare needs. But HSMT's goals and accomplishments are only the reflection of those who are in the Society, or more accurately, those who are active and give voice to their wants.

The greatest challenge of HSMT for the future is to be flexible enough to keep fulfilling changing needs. The old-timers are not timid about communicating their desires. But it is the younger members or future members who will inherit this organization, and we must not lose sight of their needs or potential needs. This we cannot do without good communication and a greater representation of youth.

Will the structure of HSMT have to change, just as the ASMT changed, and separate into districts? It isn't too early to be thinking about the possibility! Shall we elect representatives from the neighbor islands and pay for their trips to our regular meetings? Shall we ignore them until there are enough to create district societies on each island?

Is there a place in our structure for the laboratory aides? Can we ignore them until they organize, just as the practical nurses have? How will the patients and our members best be served?

Will the time soon be here when we are no longer interested in the whole field of medical technology, but barely have time to learn about and improve ourselves in our own specialties? Shall we plan now for subsocieties on bacteriology, blood-banking, etc.?

Nothing seems quite as comfortable as our own familiar bed, our own familiar rut. But sooner or later that old mattress will have to be replaced, and we will find ourselves walking unfamiliar paths. The future of HSMT is indeed a challenge, and it is in *your hands*, those of you who truly care.

ELIZABETH J. HUGHES, MT(ASCP)
President-Elect

*Who Is Responsible for MEMBERSHIP?**

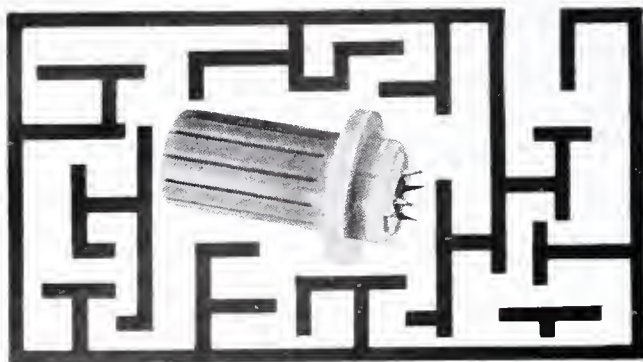
Our first reaction to this question might be "the Committee Chairmen, of course! The local chairman, the state chairman and the national chairman." Certainly, these individuals have certain responsibilities to plan drives, provide materials and generate effective results.

However, the essential element in a membership promotion plan is YOU!! the current active member!! You can initiate interest that we cannot hope to reach. Your own action and reaction relative to the professional activities is bound to be a stimulus to your colleague. Your invitation to membership is a personal one, not an impersonal mailing. You have the privilege of informing a person with whom you work that you would like to *recommend* him for membership in ASMT and provide him with an application which has your signature, attesting to your interest in him and the Society.

Recently there have been special national mailings to those persons who have specialty certificates from the Board of Registry. You can help us by reinforcing this invitation to these very important persons. You can help us by contacting those within your laboratory who have bachelor degrees, who are not MT(ASCP)'s on our mailing list. With your individual and personal help . . . ASMT will continue to grow. Thank you for your help.

LOIS A. BALLARD, *Chairman*
ASMT Membership Committee

* Editor's note: This ASMT News Release is being reprinted without change because we can't say it any better. ■



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In Memoriam continued from 302

Booneville, New York. Later he settled in St. Louis, Missouri.

Dr. Tuttle died in Arlington, Virginia, on February 19, 1958, at the age of 86.

He was a member of the Hawaii Medical Society.

County Society News continued from 305

to the Advisory Council to Hale Makua Home Nursing Care Service. A discussion followed on the licensing of doctors of osteopathy and the Board of Governors was instructed to follow this up. The Society was urged to support the RMP program for continued medical education at Maui Memorial Hospital. It was voted to have the county appointments coincide with those of the HMA. Dr. Uehara announced that the dentists had agreed to a drive for detection of oral cancer. It was voted to send ten students to the Careers Day Program in Honolulu and that the amount needed for half the fare for five and the full fare for the other five would be paid by the Society. A motion to have the Society sponsor a Medical Explorer Scout Troop was tabled for a future meeting. The Medicare program in relation to the various plantations was discussed. It was voted to have the Society subsidize necessary trips to Honolulu by the Society officers. It was voted to have arrangements made to invite speakers for medical public relations. The sex education programs being advocated by the Department of Education were discussed. Two physicians were approved for membership, Dorothy N. LaFon and Helen Percy.

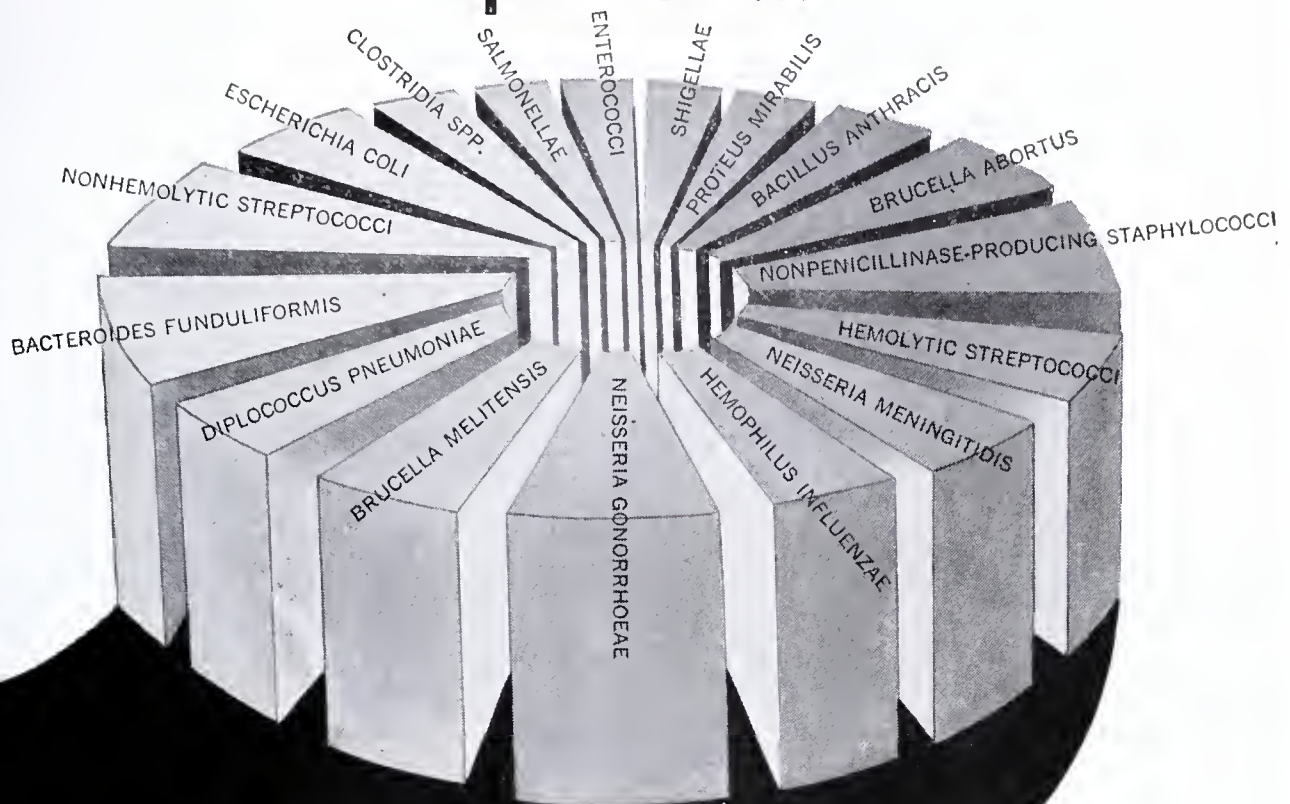
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Contraindications: A history of allergic reactions to penicillins or cephalosporins and infections due to penicillinase-producing organisms.

Precautions. Typical penicillin-allergic reactions may occur, especially in hypersensitive patients. Mycotic or bacterial superinfections may occur. Experience in newborn and premature infants is limited and caution should be used in treatment, with frequent organ function evaluations. Safety for use in pregnancy is not established. In gonorrheal therapy, serologic tests for syphilis should be performed initially and

monthly for 4 months. Assess renal, hepatic and hematopoietic function intermittently during long-term therapy.

Adverse Reactions: Skin rash, pruritus, urticaria, nausea, vomiting, diarrhea and anaphylactic reactions. Mild transient elevations of SGOT or SGPT have been noted. Black tongue has been noted in some patients receiving the Chewable Tablets.

Usual Dosage: Adults—250 or 500 mg. q. 6 h. (according to infection site and offending organisms). Children—50-100 mg./Kg./day in 3 to 4 divided doses (depending on infection site

and offending organisms). Bacterial meningitis—150-200 mg./Kg./day in 6 to 8 divided doses. Children weighing more than 20 Kg. should be given an adult dose when prescribing orally. In parenteral administration, children weighing more than 40 Kg. should be given an adult dose. Beta-hemolytic streptococcal infections should be treated for at least 10 days.

Supplied: Capsules—250 mg. in bottles of 24 and 100. 500 mg. in bottles of 16 and 100. For Oral Suspension—125 mg./5 ml. in 60, 80 and 150 ml. bottles. 250 mg./5 ml. in 80 and 150 ml. bottles. Chewable Tablets—125 mg. in bottles of 40. Injectable—for I.M./I.V. use—vials of 125 mg., 250 mg., 500 mg., and 1 Gm. Pediatric Drops—100 mg./ml. in 20 ml. bottles.

11-1/2/69

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TABLETS

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(meprobamate and ethoheptazine
citrate with aspirin)



IN BRIEF.

Contraindications: History of sensitivity or severe intolerance to aspirin, meprobamate or ethoheptazine citrate.

Warnings: **USE IN PREGNANCY:** Safety for use during pregnancy or lactation has not been established; therefore, it should be used in pregnant patients or women of child-bearing age only when the physician judges its use essential to the patient's welfare.

Precautions: Keep out of reach of children. Not recommended for patients 12 years old or less. Carefully supervise dose and amounts prescribed, especially for patients prone to overdose themselves. Excessive prolonged use of meprobamate in susceptible persons—as alcoholics, ex-addicts, severe psychoneurotics—has resulted in dependence or habituation. Withdraw gradually after prolonged excessive dosage to avoid possibly severe withdrawal reactions including epileptiform seizures. Warn patients of possible reduced alcohol tolerance, with resultant slowed reactions and impaired judgment and coordination. If drowsiness, ataxia or visual disturbances (impairment of accommodation and visual acuity) occur, reduce dose. If symptoms persist, patients should not operate machinery or drive. After meprobamate overdose, prompt sleep, reduction of blood pressure, pulse and respiratory rates to basal levels, and hyperventilation are reported. Give cautiously and in small amounts to patients with suicidal tendencies. Treat attempted suicide (has resulted in coma, shock, vasomotor and respiratory collapse and anuria) with gastric lavage and appropriate symptomatic therapy (CNS stimulants and pressor amines as indicated). Two instances of accidental or intentional significant overdosage with ethoheptazine and aspirin have been reported. These were accompanied by CNS depression (drowsiness and lightheadedness) but resulted in uneventful recovery. On basis of pharmacologic data, CNS stimulation could be anticipated, with nausea, vomiting and salicylate intoxication (requires induced vomiting or gastric lavage, specific parenteral electrolyte therapy for ketoacidosis and dehydration, and observation for hypoprothrombinemic hemorrhage [usually requires whole blood transfusions]).

Adverse Reactions: Ethoheptazine and aspirin may cause nausea with or without vomiting and epigastric distress, in a small percentage of patients. Dizziness is rare at recommended dosage. Meprobamate may cause drowsiness, ataxia and rarely allergic or idiosyncratic reactions. These reactions, sometimes severe, can develop in patients receiving only 1 to 4 doses. Such patients may have had no previous contact with meprobamate and may or may not have an allergic history. Mild reactions are characterized by urticarial or erythematous maculopapular rash. Acute nonthrombocytopenic purpura with cutaneous petechiae, ecchymoses, peripheral edema and fever have been reported. If allergic reaction occurs, discontinue meprobamate; do not reinstitute. Severe reactions, observed very rarely, include fever, fainting spells, angioneurotic edema, bronchial spasms, hypotensive crises (1 fatal case), anaphylaxis, stomatitis and proctitis (1 case) and hyperthermia. These cases should be treated symptomatically including, when indicated, such medication as epinephrine, antihistamine and possibly hydrocortisone. A few cases of leukopenia, usually transient, have been reported on continuous use. Rarely, aplastic anemia (1 fatal case), thrombocytopenic purpura, agranulocytosis, and hemolytic anemia have been reported, almost always in presence of known toxic agents.

Overdosage: See precautions section for management of overdosage.

Composition: 150 mg. meprobamate, 75 mg. ethoheptazine citrate and 250 mg. aspirin per tablet.

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It's summarized on the next page.



in edema and hypertension

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chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distension, nausea, vomiting, or gastrointestinal bleeding occur. Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia,

headache, muscle cramps, orthostatic hypotension, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

Availability: White, single-scored tablets of 100 mg. and aqua tablets of 50 mg., in bottles of 100 and 1000. (B) 46-230-E

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ACTION:

It was voted that all roster changes reported by the counties for the months of October and December be accepted and approved.

It was voted to approve the Secretary's report as circulated.

REPORT OF THE TREASURER

The Treasurer's report was presented and discussed.

ACTION:

It was voted that the auditor's report as circulated be accepted and placed on file.

It was voted to approve the Treasurer's report as circulated.

REPORT OF COMMISSIONS AND COMMITTEES

Bureau of Research and Planning: The Bureau recommended to the HMA Council that the Sanazaro Report be accepted in principle and that first steps be initiated. The Bureau pointed out that correspondence with Dr. Sanazaro will be continued and further definitions will depend upon Council acceptance of this recommendation. The Council was advised that first steps would be to poll the HMA membership re their feeling about an office audit being done. It was pointed out that a committee of Comprehensive Health Planning is thinking about doing something along this line.

ACTION:

It was voted to accept the report of the Bureau as circulated.

continued page 320

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Hawaii Medical Ass'n continued from 319

Finance Committee: The report of the Finance Committee was circulated and noted.

ACTION:

It was voted to accept the report as circulated.

Nominating Committee: The chairman reported that the committee met just before the Council Meeting. The nominees who have agreed to serve if elected are as follows:

President Elect.....John J. Lowrey
Treasurer.....Herbert Y. H. Chinn
AMA Delegate.....George H. Mills
Alternate AMA Delegate.....Theodore T. Tomita
Councilor from Oahu.....Richard D. Moore
Councilor from Oahu.....Grover H. Batten

Commission on Education and Scientific Research: The Commission's report was circulated and discussed. The Commission had three recommendations for the Council to act on: (1) That the Council direct the Medical Education Committee to draft a position for the Council and House of Delegates to take relative to the University's full-time faculty billing for treatment of staff patients. (2) That the HMA endorse the concept of a statewide council as developed by the Medical Education Subcommittee on Continuing Medical Education and that this committee be authorized to proceed to contact the various groups outlined in its report. (3) That the Medical Education Committee begin immediately to revise the HMA's RMP grant application for continuing medical education.

ACTION:

It was voted that no action be taken on recommendation #1 and that it be placed on file.

It was voted that recommendation #2 be revised to read as follows: "That the Hawaii Medical Association sponsor the development of a statewide council as developed by the Medical Education Subcommittee on Continuing Medical Education and that this committee be authorized to proceed to contact the various groups outlined in its report.

It was voted to revise recommendation #3 to read as follows: "That the Medical Education Committee begin immediately to revise the HMA's RMP grant application for continuing medical education and to vigorously pursue other methods of financing for the proposed Council and that HMA be the grantee institution.

It was voted to accept the report as amended.

Commission on Internal Affairs: The report was circulated and discussed. The following recommendations were made: (1) That the annual meeting banquet be at the Hilo Yacht Club. (2) that the tennis and fishing tournaments be held in Honolulu prior to the meeting. (3) that the golf tournament be at Mauna Kea, and (4) that the Sportsmen's Night be held at the AJA Hall on Friday following the Golf Tournament.

ACTION:

It was voted to accept the recommendations of the Commission on Internal Affairs.

There was considerable discussion about future conventions and the difficulty of getting space because of the influx of tourists and the many conventions being planned for Hawaii.

ACTION:

It was voted that the HMA staff lay out plans for the next five conventions.

continued page 325



BLEMISHES?

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or engage in other activities re-
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this preparation. Hypnotics, seda-
tives, or tranquilizers if used with
BENYLIN EXPECTORANT
should be prescribed with caution
because of possible additive effect.*

*Diphenhydramine has an atro-
pine-like action which should be
considered when prescribing
BENYLIN EXPECTORANT.*

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reactions may affect the nervous,
gastrointestinal, and cardiovascu-
lar systems. Drowsiness, dizziness,
dryness of the mouth, nausea, ner-
vousness, palpitation, and blurring
of vision have been reported. Al-
lergic reactions may occur.*

*PACKAGING: Bottles of 4 oz.,
16 oz., and 1 gal.*

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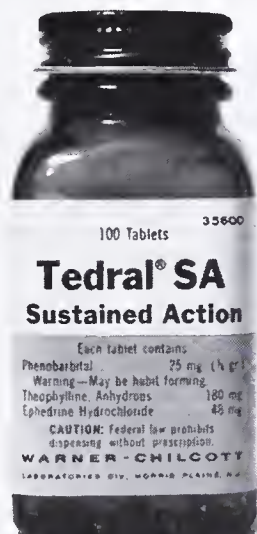


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Each double-layered, uncoated, coral/mottled white tablet of Tedral SA contains 180 mg. anhydrous theophylline (90 mg. in the immediate release layer and 90 mg. in the sustained release layer); 48 mg. ephedrine hydrochloride (16 mg. in the immediate release layer and 32 mg. in the sustained release layer); 25 mg. phenobarbital.

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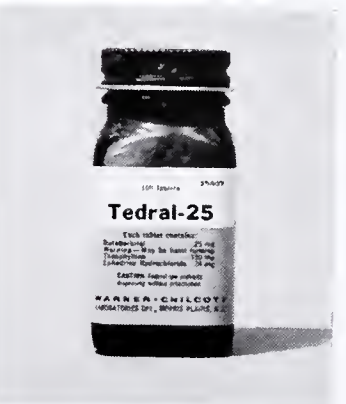
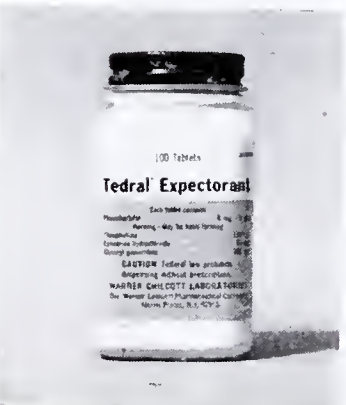
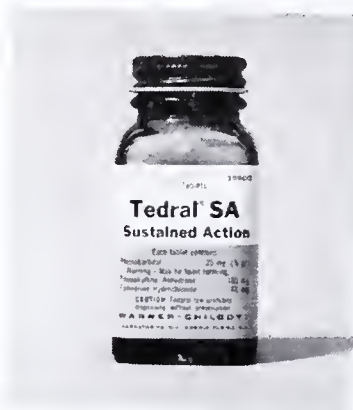
Each white uncoated, scored tablet contains 130 mg. theophylline, 24 mg. ephedrine hydrochloride, and 8 mg. phenobarbital.

Tedral[®] Expectorant

Each white tablet contains 130 mg. theophylline, 24 mg. ephedrine hydrochloride, 8 mg. phenobarbital, and 100 mg. glyceryl guaiacolate.

Tedral-25[®]

Each salmon-pink uncoated, scored tablet contains 130 mg. theophylline, 24 mg. ephedrine hydrochloride, and 25 mg. butabarbital.



Indications: Tedral, Tedral SA, Tedral-25, and Tedral Expectorant are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal, or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of *b.i.d.* dosage.

Tedral-25 is indicated when there is excessive nervousness, apprehension or sensitivity to ephedrine.

Tedral Expectorant is indicated only when both relaxation of bronchospasm and expectoration are desired.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications: Sensitivity to any of the ingredients; porphyria.

Warning: Phenobarbital or butabarbital may be habit-forming.

Precautions: Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions: Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Dosage: Tedral. Adults (average prophylactic or therapeutic dosage)—one or two tablets every 4 hours. With the one-tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. Children (over 60 lb.)—one-half the adult dose.

Tedral SA. Adults (average prophylactic or therapeutic dosage)—one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. Dosage in children under 12 is not recommended because usage has not been established.

Tedral-25. Adults (average prophylactic or therapeutic dosage)—one or two tablets every 4 hours. With the one-tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. Children (over 60 lb.)—one-half the adult dose.

Tedral Expectorant. Adults: One or two tablets *q.i.d.* With the one tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. Dosage in children under 12 is not recommended because usage has not been established.

Supplied: Tedral. Bottles of 24, 100 and 1000 tablets.

Tedral SA. Bottles of 100 and 1000 tablets. Tedral SA is available on prescription only.

Tedral-25. Bottles of 100 tablets. Tedral-25 is available on prescription only.

Tedral Expectorant Tablets. Bottles of 100. Tedral Expectorant is available on prescription only. Full information is available on request.

T-GP-91-2C



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There was also considerable discussion about the scientific session and who has been invited to speak. It was noted that the Scientific Program Committee has not had a meeting since the last Council Meeting. It was brought to the Council's attention that Dean Cutting has invited the President of the AMA to Hawaii on May 26 which is after the HMA's Annual Meeting. It was noted that an invitation has not been extended to Dr. Wilbur by the HMA.

ACTION:

It was voted that the HMA invite Dr. Dwight Wilbur, President of the AMA to be in attendance at the HMA Annual Meeting.

Commission on Legislation: The Commission's report was circulated and discussed. The Commission asked the Council to act on two recommendations: (1) that the Legislative Committee be authorized to select a new counsel at a salary commensurate with his abilities and taking into consideration the lengthy sessions mandated by the voters; and (2) that the Medical Practice Act Committee be authorized to study the entire problem of the relationship of the medical profession and osteopathy by taking into consideration the action taken by the House of Delegates.

The Council was informed that Mr. Edwin Honda and Mr. Roy Takeyama have suggested three names for consideration. The chairman pointed out that these men are capable and highly experienced men in their field.

ACTION:

It was voted that the Legislative Committee be authorized to interview and recommend the selection of the Legislative Counsel, and that his appointment and salary be subject to Council approval.

There was considerable discussion about the practice of osteopathy. It was noted that two osteopaths on Maui have hospital privileges and one on the Island of Hawaii has hospital privileges. It was pointed out that osteopaths do not have to take the same examination as the MD's in order to be licensed. It was further noted that at the previous council meeting the Maui County Medical Society resolution was reviewed, discussed, and referred to the Medical Practice Committee for action. It was suggested that the existing statutes of the State of Hawaii be amended or changed to provide the same examination for both MD's and osteopaths.

ACTION:

It was voted to reaffirm Council action of the previous meeting and that the Medical Practice Act and Legislative Committees be asked to act on this matter.

Commission on Medical Services: The report of the Commission was circulated and discussed. The Chairman reported that the Commission was asked to act upon a

communication from the DSS re payment of bills. The Commission voted that since the HMA and DSS negotiated a contract based on the HRVS that all physicians should bill by code number whether they use 5.0 or their usual conversion factor, and if this is done, payment of bills will be speeded up. This action was called to the attention of the HMA membership in the last Newsletter. The question was that DSS wanted the HMA to circulate this bulletin to the members.

ACTION:

It was voted to file the Department of Social Services bulletin.

It was also voted that the Commission on Medical Services or one of its committees negotiate a new fee schedule with DSS.

Commission on Public Health: The Commission's report was circulated and discussed. The Commission submitted three recommendations for Council action: (1) That the recommendation of the Automotive Safety Committee with reference to the make-up of the Advisory Board to the State Department of Transportation be approved and that the HMA endorse the concept of this board. (2) That the Legislative Committee be apprised of the difficulties in recruiting a competent school physician for the stipulated salary and asked to work with the Legislature on this problem. (3) That Mr. Smyser be advised of the HMA position on leprosy as follows: (a) The HMA urges that all reference to and guidance for leprosy control and treatment, except for mandatory reporting (as in the case of smallpox, diphtheria, etc.), be removed from the Revised Laws of Hawaii and made a function of the Department of Health under its regulatory powers. (b) The HMA feels that enforced institutional confinement for leprosy treatment is not justified by modern medicine.

ACTION:

It was voted to approve the make-up of a Medical Advisory Board to the State Department of Transportation and that the physicians appointed serve anonymously and without pay.

It was also voted to approve recommendations Nos. 2 and 3.

Dr. Stephenson, Chairman of the Commission on Public Health, informed the Council that the School Health Committee, the Mental Health Committee, members of The Academy of General Practice, and members of the Academy of Pediatrics previewed and discussed the educational TV film series *Time of Your Life*, which is to be presented to parents and fifth and sixth grade students under the auspices of the Department of Education. The School Health Committee of the HMA and the physicians from the Mental Health Committee of HMA, Academy of General Practice, and Academy of Pediatrics endorse the concept of family life and sex education in the schools as part of the total health education program and support the Department of Education's ETV

continued page 328

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Hawaii Medical Ass'n continued from 325

series *Time of Your Life*. The second set of video tapes, *Health: Your Decision*, directed to tenth through twelfth graders, was also shown. The physicians present felt that this tape deserved further review and did not feel that they could support this at this time.

ACTION:

It was voted to support the development of and institution of a well-planned comprehensive student health program. This program is to include a well-developed sex education program that the HMA will volunteer to help develop and support. More specifically, in relation to the health education films, the HMA committees have not had the opportunity to adequately review the proposed films scheduled to be shown and therefore cannot pass judgment.

Commission on Interprofessional and Public Relations: The Council was informed that the Nurses Liaison Committee has had discussion around the problem of nurses dispensing drugs in the hospital after daylight working hours. It was the overwhelming disposition of the nurses' representative that this practice should cease. There was some discussion.

ACTION:

It was voted to instruct the nurses that the doctors feel this is a problem between the nurses and the hospitals.

The chairman of the Message of the Month Committee wishes to go ahead with the luncheon for the women who help with the deliveries. The Council agreed this was in order.

continued page 332



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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.

Adverse Reactions: Overstimulation, restlessness, insomnia, g.i. disturbances, diarrhea, palpitation, tachycardia, elevated blood pressure, tremor, sweating, impotence and headache.

Supplied: In bottles of 50.

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Contains 15%
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Unavoidable.

Contraindication: Carcinoma of the prostate, due to methyltestosterone component.

Warning: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosages: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

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Hawaii Medical Ass'n continued from 328

UNFINISHED BUSINESS

Report of Study of PL 89-239: The Commission on Education & Scientific Research was charged by the Council to study Public Law 89-239 to determine if the Regional Medical Program operation in Hawaii is in line with the intent of Congress. The Commission is made up of the commissioner, the five HMA officers, and the chairmen of the committees which make up the Commission. The Commission was expanded for the purpose of making this review, with approval of the Council, to include the following additional members: Drs. Sam Allison, Unoji Goto, Glenn Kokame, Chew Mung Lum, Richard Mamiya, Robert Nordyke, Verne Waite, and Livingston Wong. The Commission studied the law and invited members of the RMP Steering Committee, and members of the HMA who discussed some of their problems with RMP Hawaii. The Commission's report was circulated to the Council.

A minority report submitted by Dr. C. M. Lum re two points was also circulated: (1) true representation and (2) better communication from RMP re status of grants. The Chairman also pointed out that Mr. Wilson Cannon had requested a copy of the report on the study of PL 89-239.

ACTION:

It was voted to send a copy of the report on the study of PL 89-239 as amended to Mr. Wilson Cannon.

It was voted that Recommendation C and Conclusion D not be approved.

It was voted to accept Conclusions A, B, & C.

It was voted that the President of the HMA select a committee to have a meeting or meetings with Mr. Cannon and RMP representatives to discuss reorganization with true representation in RMP-Hawaii and that this meeting is to include discussion of a full-time administrator.

It was voted that the President of HMA write a letter to Dr. Stanley Olson to discuss the RMP-Hawaii problem with RMP staff and that a carbon copy of the letter be sent to Dr. Masato Hasegawa.

It was voted that the Bureau of Planning & Research be asked to study in depth PL 89-749 along the same lines which was done for PL 89-239.

NEW BUSINESS

Report of the AMA Miami Meeting by Dr. Richard D. Moore: Dr. Moore gave a brief report of the Miami meeting. He mentioned that there was discussion of osteopaths and that the AMA is suggesting all medical societies accept osteopaths as members. Another item of interest which was discussed at the Miami meeting was that the National Blue Shield Plans are planning to change their Bylaws to again require Medical Society approval of member plans.

Remarks by AMA Field Representative Richard G. Layton: Brief remarks were made by Mr. Layton on his responsibilities as AMA Field Representative and also as AMPAC representative. He gave a short report of the meeting called by former HEW Secretary Cohen.

The meeting was adjourned at 1:15 A.M.

R. VARIAN SLOAN, M.D.
Secretary

Notes and News continued from 308

the project of bringing war-injured Viet Nam children here for care. Walter Strode led a free theological university on "Man Come of Age" at the Off Center Coffeehouse.

"With Hawaii's Amateurs," Fred Lam, Jr., (KH6GG) talked on safety and electric shock resuscitation at a

continued page 335

See next page for prescribing information



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DEMETHYLCHLORTETRACYCLINE



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DECLOMYCIN acts against many strains of *H. influenzae*, pneumococci and streptococci, the most common invaders. In otitis media, where it is difficult to isolate the causative organism, this coverage may be important. However, some strains may be resistant and other pathogens can be involved.

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When specimens are obtainable, your culture studies will indicate the usefulness of DECLOMYCIN.

Effectiveness: DECLOMYCIN Demethylchlortetracycline should be equally or more effective therapeutically than other tetracyclines in infections caused by organisms sensitive to the tetracyclines.

Contraindication: History of hypersensitivity to demethylchlortetracycline.

Warning: In renal impairment, usual doses may lead to excessive accumulation and liver toxicity. Under such conditions, lower than usual doses are indicated, and, if therapy is prolonged, serum level determinations may be advisable. A photodynamic reaction to natural or artificial sunlight has been observed. Small amounts of drug and short exposure may produce an exaggerated sunburn reaction which may range from erythema to severe skin manifestations. In a smaller proportion, photoallergic reactions have been reported. Patients should avoid direct exposure to sunlight and discontinue drug at the first evidence of skin discomfort. Necessary subsequent courses of treatment with tetracyclines should be carefully observed.

Precautions: Overgrowth of nonsusceptible organisms may occur. Constant observation is essential. If new infections appear, appropriate measures should be taken. In infants, increased intracranial pressure with bulging fontanels has been observed. All signs and symptoms have disappeared rapidly upon cessation of treatment.

Side Effects: Gastrointestinal system—ano-

rexia, nausea, vomiting, diarrhea, stomatitis, glossitis, enterocolitis, pruritus ani. Skin—maculopapular and erythematous rashes; a rare case of exfoliative dermatitis has been reported. Photosensitivity, onycholysis and discoloration of the nails (rare). Kidney—rise in BUN apparently dose-related. Transient increase in urinary output, sometimes accompanied by thirst (rare). Hypersensitivity reactions—urticaria, angioneurotic edema, anaphylaxis. Teeth—dental staining (yellow-brown) in children of mothers given this drug during the latter half of pregnancy, and in children given the drug during the neonatal period, infancy and early childhood. Enamel hypoplasia has been seen in a few children. If adverse reaction or idiosyncrasy occurs, discontinue medication and institute appropriate therapy. Demethylchlortetracycline may form a stable calcium complex in any bone-forming tissue with no serious harmful effects reported thus far in humans.

Average Adult Daily Dosage: 150 mg q.i.d. or 300 mg b.i.d. Should be given 1 hour before or 2 hours after meals, since absorption is impaired by the concomitant administration of high calcium containing drugs, foods and some dairy products. Treatment of streptococcal infections should continue for 10 days, even though symptoms have subsided.

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DEMETHYLCHLORTETRACYCLINE

Capsules: 150 mg; **Tablets:** film coated, 300 mg, 150 mg and 75 mg of demethylchlortetracycline HCl.

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meeting of the Honolulu Amateur Radio Club. During a drug abuse panel discussion, **Harry Shirkey**, Director of Children's Hospital, said, "Every civilization had some sort of stimulants and depressants. . . . In every era, people have found things in their environment to give them kicks. . . . In many cases, drugs cause 'placebo reaction.' Sometimes this can be even more important than the actual effect. . . ." The panelists likened the use of drugs by children to the use of alcohol and tobacco by adults. Harry agreed, "We can't shake the tobacco habit and we are asking them to shake these other habits. . . ." (Sometimes we wonder whether we are for or against drug abuse. It seems to depend upon which drug!) **Felix Lafferty** was on a panel discussing "Sex education: its place in the teaching of science," which was the theme of the fall conference of the Hawaiian Teachers Association. (Sex, it seems, is a problem even with science teachers.) **Ed Chesne**, President-elect of the Hawaii Heart Association, was guest speaker for the Wahiawa Hospital Association and spoke on "First Aid for Faltering Hearts." **John Stephenson** spoke on the "Use of Narcotics by Adolescents" at the Aikahi School PTA. **Clifford Mirikitani** spoke on "Cancer" at the Nuuanu Congregational Church Fellowship Circle. **Harold Lawson** conducted a "Five-Day Plan" for stopping smoking at the Castle Memorial Hospital (Probably easier said than done, eh?).

In December, **Ed Chesne** gave a pep talk to Volunteers for Heart Sunday. **Dick Ando**, School Board chairman, summarized the Board's actions and accomplishments for the past two years and said, "Hawaii's first elected school board has tackled some heavy issues in the past two years and can be proud of what has been done." (We are proud of Dick, who has been forging ahead, come hell or high water. . . .)

In January, **Harry Shirkey** discussed the relationship between drugs and birth defects at a Teen Age Conference on Birth Defects at Children's Hospital while **Sharon Bintliff**, Medical Director of the Birth Defects Center, spoke on the treatment of birth defects. Not to be outdone, **Walton Shim**, Assistant Director of the Birth Defects Center, addressed the Our Lady of Sorrow School parent-teacher group and discussed birth defects and their treatment. Our still bewhiskered **Robert Bell**, Chairman of the Medical Committee of the Hawaii Committee on Alcoholism, warned that "alcoholism now ranks with cancer, heart disease, and mental illness as a national health problem. . . . The real problem is to determine when a drinker becomes an alcoholic." Peripatetic lecturer **Ed Chesne** spoke on "New Developments in Cardiac Care" at a noon meeting of the West Honolulu Rotary Club. Again, **John Stephenson** was on a panel which dealt with "What do drugs have to do with me," during an open community forum sponsored by the YWCA. Patriarchal **Don Marshall** was on a panel discussing "Our Changing Sex Mores: Fact or Fantasy?" at the Hawaii Psychological Association meeting. Don feels that our children don't have enough to do to keep them out of mischief. "We pamper them too much and don't demand early in childhood that our youngsters help pull their own weight in maintaining the family." Our venerable editor, **Harry Arnold, Jr.**, spoke on leprosy at a luncheon meeting of the West Honolulu Rotary Club. **Livingston Wong** spoke on "Utilization Review: How it Functions, and its Objectives" at an institute of the Hawaii Association of Medical Record Librarians. On the Big Island, **Paul Caldwell** discussed the medical aspects of abortion at the Hilo Woman's Club. Paul feels that "it is difficult for doctors to agree on the subject of abortion or to accept abortion from a medical standpoint, because they are thoroughly trained to save lives. . . . Perhaps the next generation could accept the idea, 'But I find it hard to terminate the life of an unborn.'"

In February, **Clifford Straehley** spoke to the Associated Chinese University Women at their luncheon meeting. His talk was appropriately called, "Dying to

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Smoke." Clifford regards smoking as "the greatest public health menace in the United States today about which something can be done. . . . The only effective treatment is the tincture of will power." Clifford related how he smoked up to 2½ packs a day until 12 years ago, when he saw the light. (We find that the best crusaders are those who have themselves given up something, be it alcohol, smoking, or women. This may be a sadistic trait, i.e., wanting others to share their agony.) **Alfred Morris** spoke on "The Human Heart and How to Keep Healthy and Alive" at the Chinese Woman's Club luncheon meeting. **Cal Sia** was one of the panelists discussing brain damage and learning difficulties at a meeting of the Hawaii Psychological Association. **James Mertz** spoke to the Maunawili PTA meeting on "A review of the current situation with regard to drugs and glue sniffing."

Medically Speaking . . .

During the program on diabetes with an all-Maui panel consisting of Milton Howell, Dennis Fu, John Morris, and Mark Sowers, some of the vague questions could not be answered forthrightly without more pertinent facts. Sensing the hesitancy in some of the panelists' answers, a recalcitrant caller demanded, "Why is everyone hedging except for Dr. Gordon Burke?" (Gordon is our non-physician moderator, on whom we shall soon have to confer a honorary M.D. degree for moderating our program every week for the past five years).

Grant Stemmerman, in his "opener" on the program "Diseases of the Migrant," stated that "The healthiest Americans are naturalized Japanese men. The second healthiest Americans are their sons." Since in most racial groups, the women have greater longevity, an obviously worried Japanese-American woman asked, "Why do Japanese-American men live longer than their women?" The answer was a flat and disappointing "We don't know. . . ."

Sportsmen

The Turf Diggers: The inclement weather over the past few months must be responsible for the dearth of golf tidbits. We did learn that **Don Maruyama** and **Mike Okihiro** recently qualified with a net 76 in the Francis Brown 4-Ball Tournament, only to be eliminated in the second round play. We wish to report that **Hideo Oshiro** has been weathering a slump since his hole-in-one at Kaanapali last year and that **Nobu Nakasone**, ardent disciple of Ben Hogan, has also been having trouble putting his brilliant shots together. "Cool" **Wakai**, who sports a 13 handicap, shot a cool 80 at Mid Pac recently and pooh poohed it as just luck. For the forthcoming HMA tournament at Mauna Kea this May, we are putting our money on two high handicappers, **Art Salcedo** and **Bill Dang**.

Tennis: We have unofficially learned that the forthcoming HMA Tennis Tournament here in Honolulu on May 13 (the Sunday after Mother's Day) will be a closed tournament with A & B flights. The Sunrise Swingers (composed of 16 tennis nuts who every Sunday morning go through the ritual of turning off their angry alarms, peering sleepily out into pitch darkness, listening hopefully for the patter of rain (which may mean a tournament cancellation) and then dragging their miserable hides to the courts to start their matches at the crack of dawn) have mustered enough courage to enter the city-wide Class C Tournament. In the first tournament play, the doubles pair of **Cal Sia** and **Hiro Tottori** won the only match out of seven matches played. In the second series, the Swingers fared better, winning four out of the seven matches. **Walton Shim** and **Simon Cheng** (Queen's resident) won their singles matches and the unbeatable first doubles team of **Cal Sia** and **Hiro Tottori** and the fourth doubles team of **Ted Tsen** and **Duke Choy** won their matches. ■

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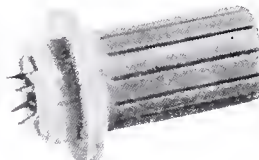
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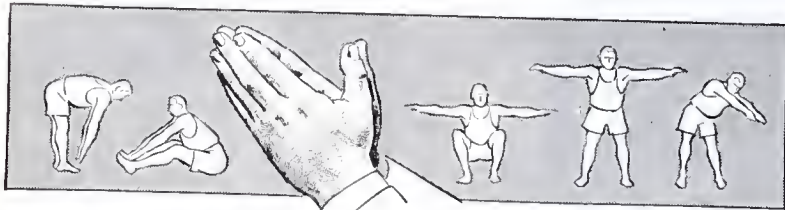


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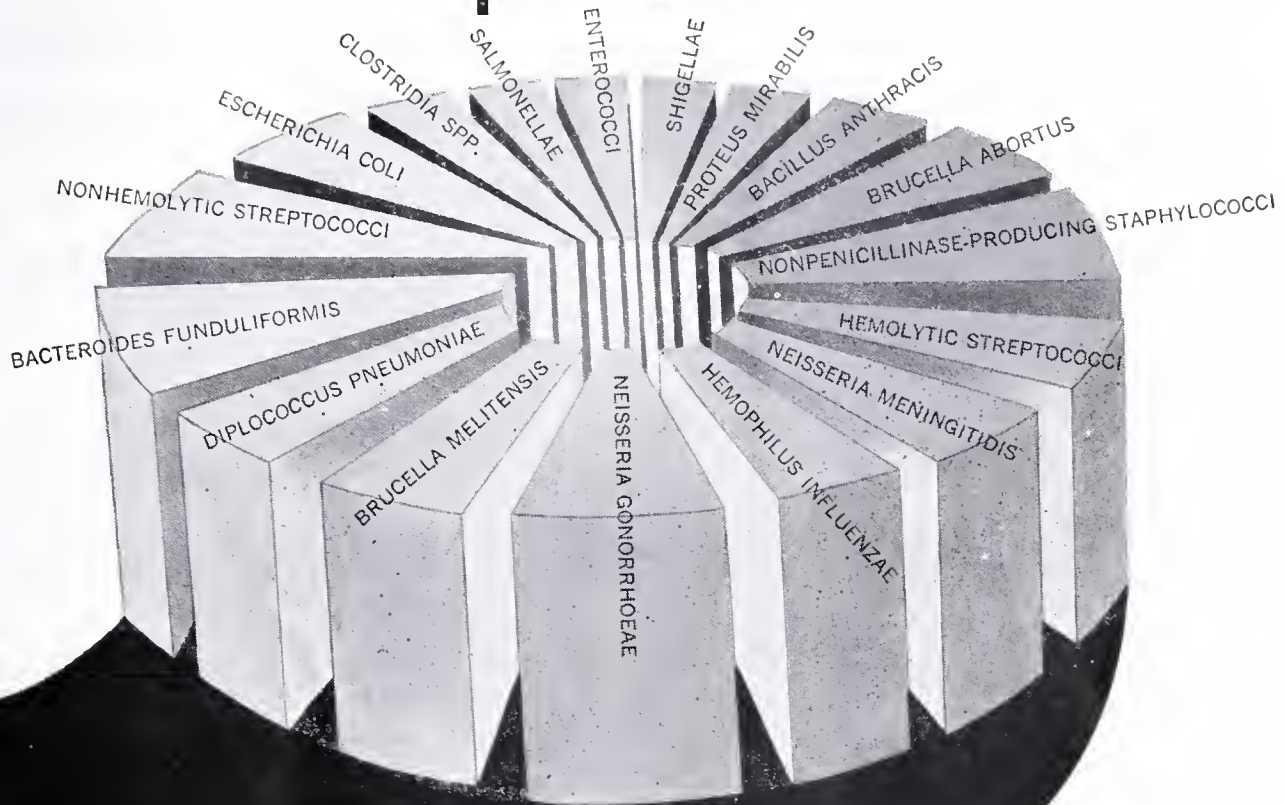
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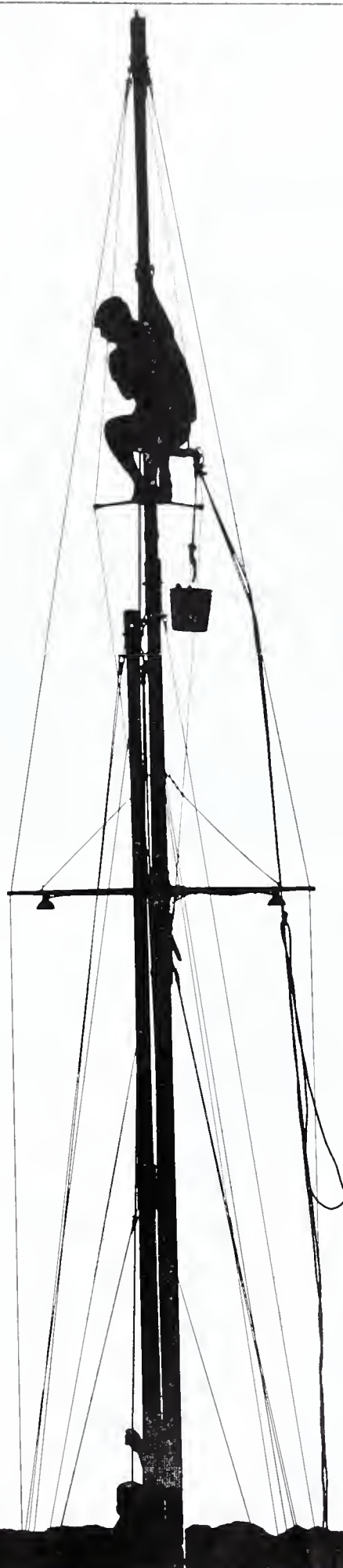
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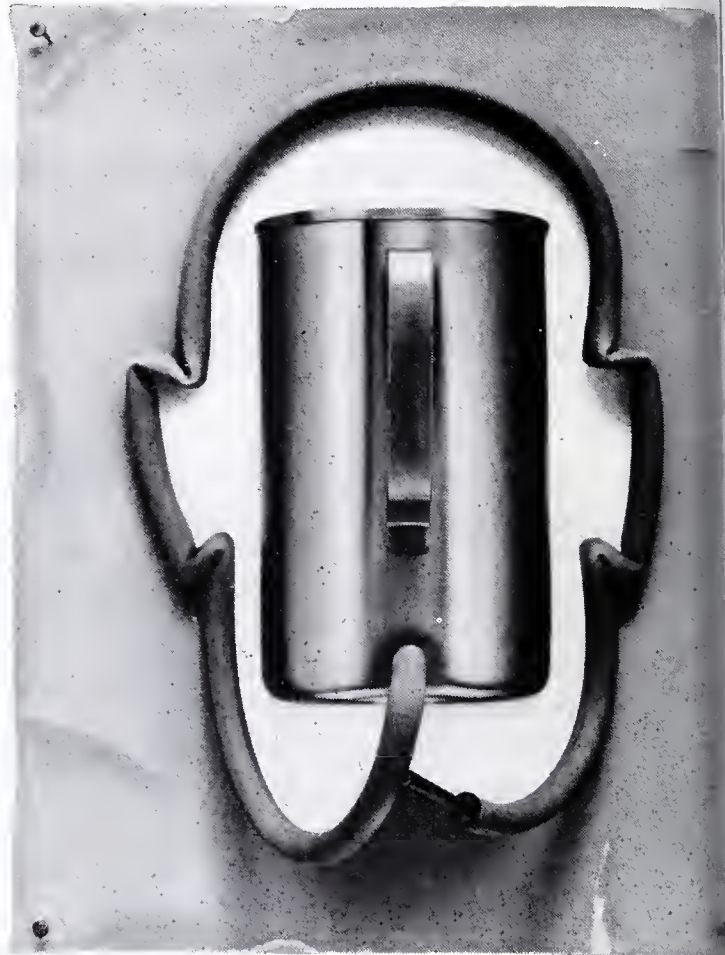
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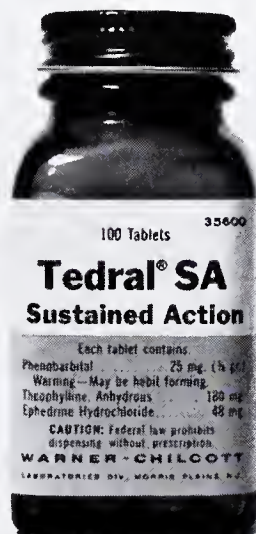
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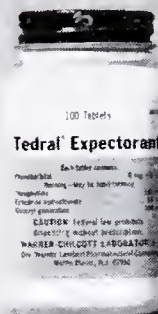
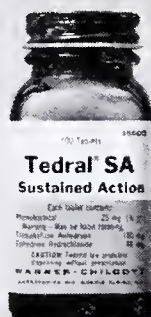
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Precautions: Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

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Tedral SA. Adults (average prophylactic or therapeutic dosage)—one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. Dosage in children under 12 is not recommended because usage has not been established.

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References. 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

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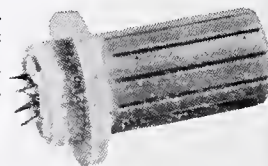
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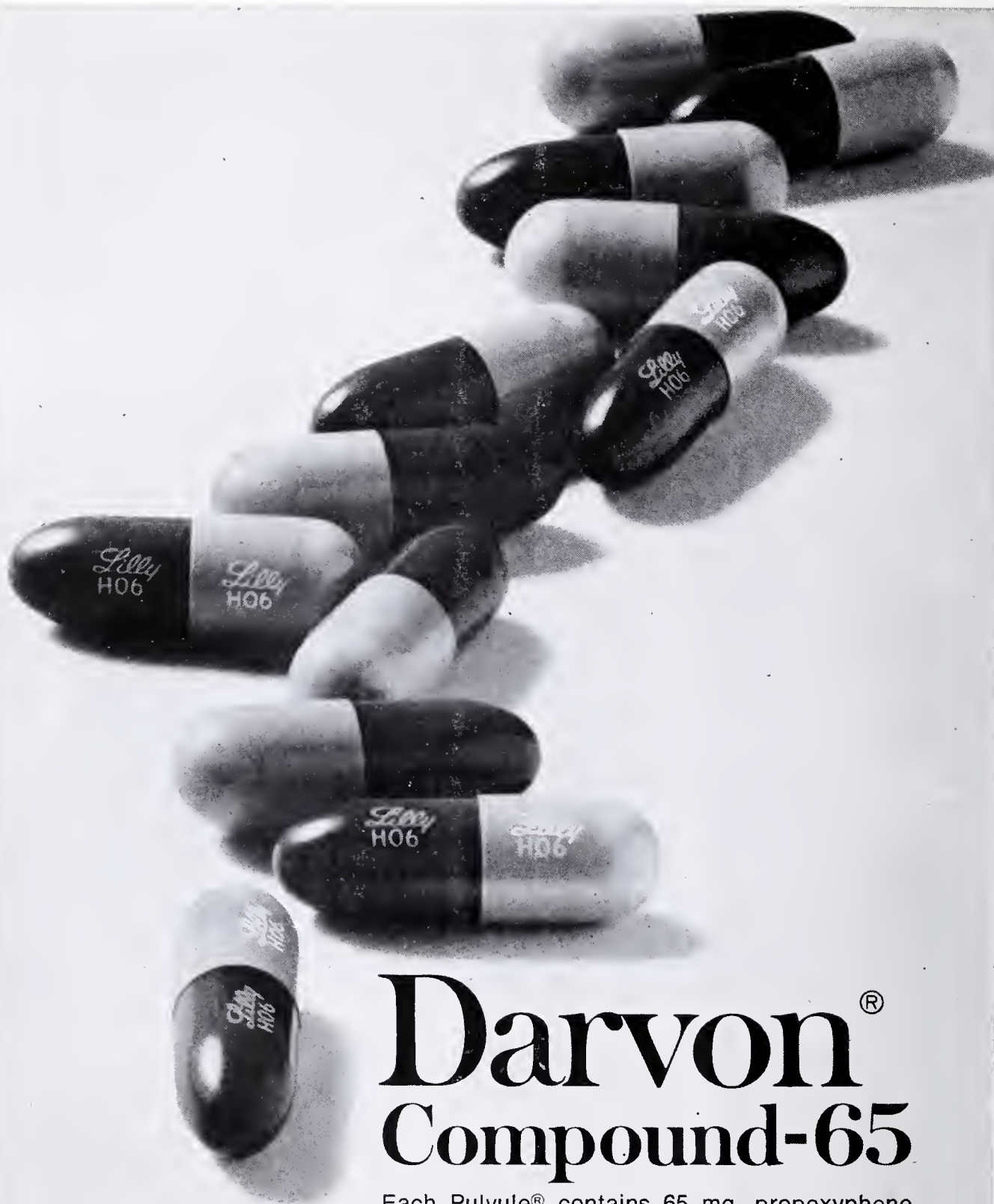
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Leprosy and Public Health in Hawaii— Changing a Policy of Isolation

K. L. GOULD, M.D.,* Honolulu

● *Historically, the decline of leprosy incidence in Hawaii may be due more to the decline of the Hawaiian population than to isolation policy. This policy is now being changed on the basis of many factors: effective drugs, direct experimental evidence of a rapid decline in infectivity after initial therapy, relative ineffectiveness of isolation as a control measure, epidemiologic evidence for the safety of home treatment, social-psychological problems of isolated patients, and enlightened attitudes in the community. Hawaii's Committee on Leprosy recommends that hospitalization for leprosy be voluntary, for medical care rather than isolation, and much shorter than heretofore. The basis and details of the Committee's recommendations are presented here.*

ON JANUARY 6, 1866, nine men and three women were beached on a rocky, isolated peninsula on the north shore of Molokai, one of the Sandwich Islands in the mid-Pacific. All were "lepers," the first boatload to be shipped to the new leprosy colony in those islands. The subsequent tragic saga of lives sentenced to that peninsula is well known. Hawaii has contributed little to total leprosy morbidity in the world and in historical perspective has been only recently affected. Nevertheless, Hawaii's leprosy victims in many ways have symbolized the plight of those afflicted with this disease everywhere, in part because of several familiar books, such as *Damien the Leper*

by Farrow, *The Path of the Destroyer* by Mouritz, *Brother Dutton* by Case, *Molokai* by Bushnell, and *Samaritans of Molokai* by Dutton. Father Damien, Brother Dutton, and Kalaupapa or Kalawao Settlement are familiar to much of the world and symbolize the admixture of dedicated service, self-sacrifice, suffering, prejudice, and social disruption attending this disease.

WAS ISOLATION A MAJOR FACTOR?

After 1866 the prevalence of leprosy in Hawaii increased markedly until 1870-1880 when there were over 1,000 cases per 100,000 population per year.¹ The prevalence of leprosy in Hawaii has fallen markedly since that time. Chung-Hoon² and Sloan³ felt that this decrease resulted from a policy of strict isolation but presented no data on this point. Hirschy¹ and Worth⁴ reported that separation decreased or eliminated secondary cases in children born to lepromatous parents. Since some degree of isolation was associated with declining incidence in other countries, as in Europe in 1400 to 1800,⁵ this conclusion appears reasonable.

However, there is evidence that isolation was not the only, or perhaps not even the major, factor in the marked decline of leprosy in Hawaii between 1880 and 1924. During this period at least 92 per cent of all cases of leprosy were of Hawaiian or part-Hawaiian extraction.⁶ Because the Hawaiian race accounted for most of the cases, the number of cases in this racial group alone largely determined the total number of cases in Hawaii. Between 1880 and 1924 the incidence rate of

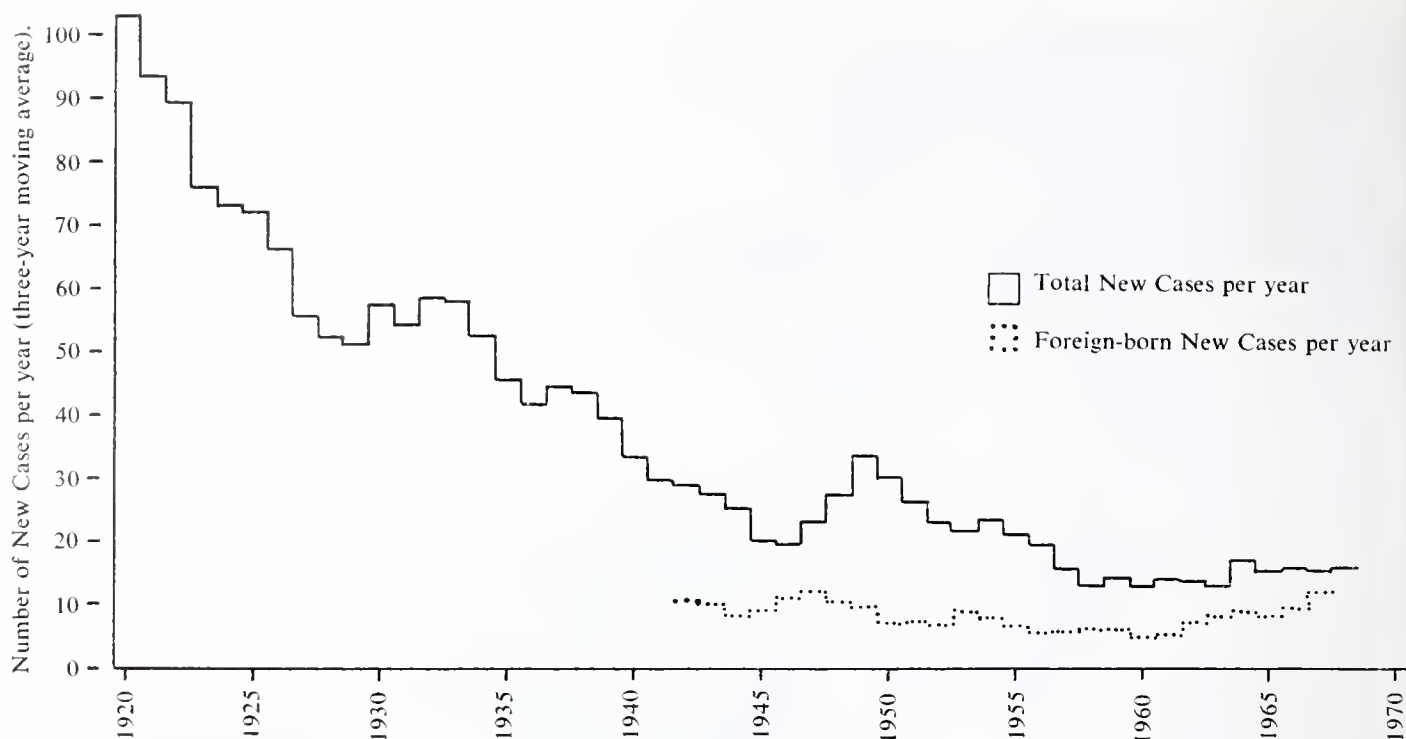


FIG. 1.—Number of new cases of leprosy per year in Hawaii, 1920-1968 (three-year moving average).

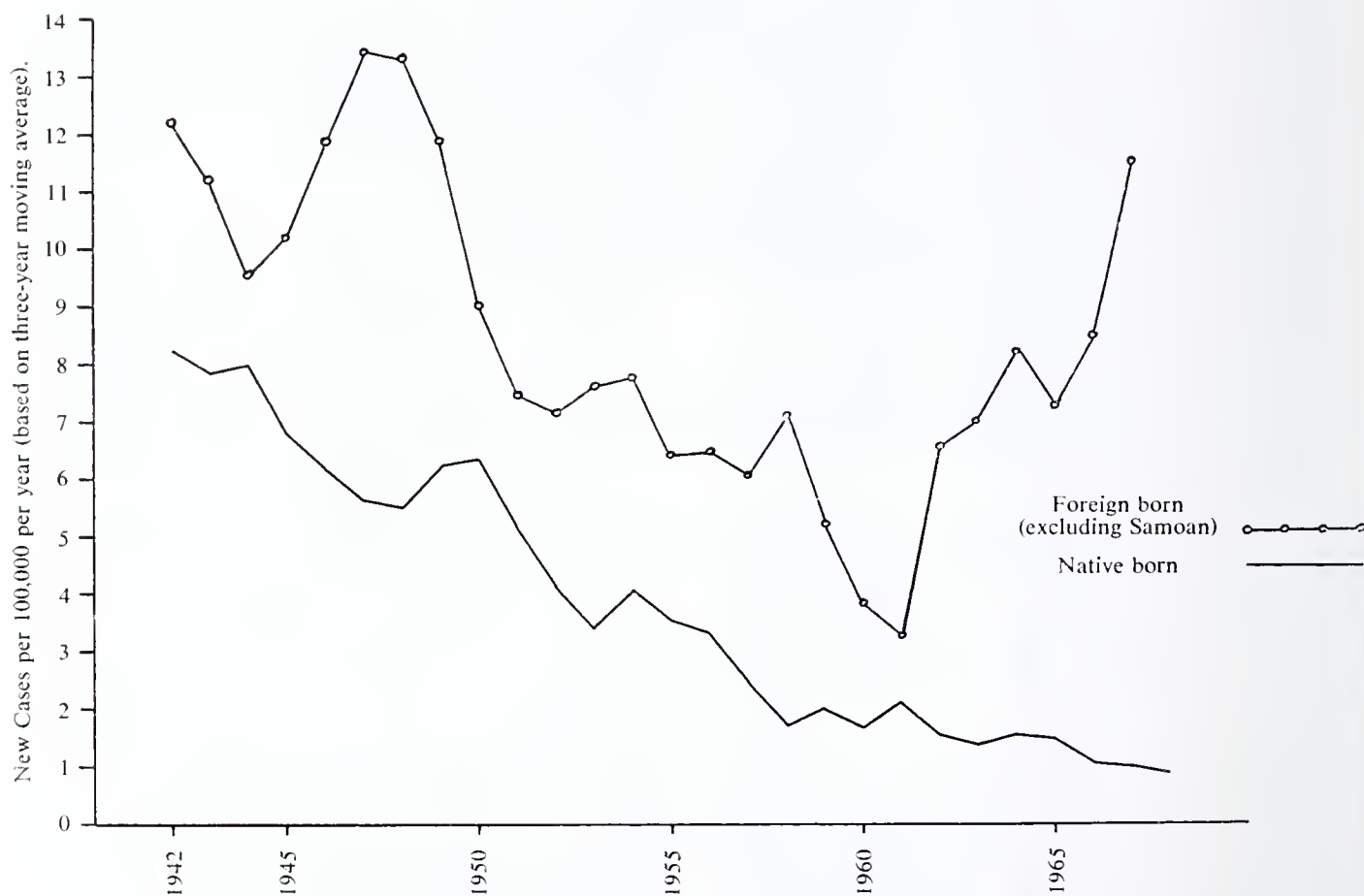


FIG. 2.—Incidence of leprosy in the native-born and foreign-born population of Hawaii, 1942-1968 (based on the three-year moving average number of case per year).

leprosy among Hawaiians (new cases per 100,000 per year) decreased only slightly, whereas the incidence rate in the total population of the islands declined markedly.⁶

This marked fall in over-all incidence was associated with two major changes in the population of the islands during this period: (a) despite a relatively small change in incidence rate within this racial group, the size of the Hawaiian population declined markedly,⁷ resulting in fewer total cases in the islands; (b) the non-Hawaiian population, which accounted for only a small portion of the total number of cases, increased markedly⁷ and further lowered the incidence rate in the islands as a whole. In other words, the incidence of leprosy in the total population of the islands decreased as the Hawaiian race diminished and the non-Hawaiian population increased.

After 1924, incidence among Hawaiians declined at the same rate as in the islands as a whole, and the effects of population change are less clear. Thus, isolation may have been one factor, but population shifts may explain much of the decline of leprosy in Hawaii during this period.

Control centered on an official territorial policy of mandatory isolation of all cases. This official policy gave rise to a complex legal leprosy code interspersed throughout the laws of Hawaii.⁸ In addition to legally enforced isolation of patients, there was special reference to leprosy in laws pertaining to marriage and divorce, estate and income taxation, claims against estates, absentee balloting, employment rights and state pensions of patients, fishing rights in waters off Kalawao, separation of infants from mothers, penalty for concealing persons with leprosy, rights and duties of kokuas (helpers), the oath of loyalty, the practice of medicine, the sentence of convicts, and the term "Hansen's Disease" instead of leprosy. Clearly the legal, social, and medical history of leprosy in Hawaii is complex and an integral part of the historical fabric of the islands—in fact, such an integral part that changing treatment policy depended on major revision by legislature of the entire health code and sections of the legal codes affecting many areas other than health.

As early as 1902 the decision to isolate a patient was routinely determined by the presence or absence of leprosy bacteria on microscopic examination of the skin.⁹ However, prior to 1911 persons were classified simply as being "a leper" or "not a leper." All "lepers" were committed to mandatory lifelong isolation and released only upon reexamination and reclassification as "not a leper." In 1911 and again in 1929 the Legislature of the Territory of Hawaii passed acts giving the Board of Health the authority to grant temporary release to patients

on the basis of laboratory findings without reclassification as "not a leper."^{10, 11} These legislative steps in the decline of isolation as a control measure paralleled recognition of the fact that a certain type of leprosy was not communicable and did not require isolation.

In 1946, sulfone drugs were introduced into Hawaii by Norman Sloan as routine therapy, only three years after their initial clinical trials at Carville, U.S.A.¹² In 1965 and 1966 Ira Hirschy, the present Director of the Hansen's Disease Program in Hawaii, took several further steps toward earlier release of isolated patients,^{13, 14} and in 1968 his efforts resulted in a limited but significant improvement in laws existing from the past.¹⁵

In 1968 this trend culminated in a Committee on Leprosy composed of six physicians and nine laymen, representing a wide range of ethnic and employment groups in Hawaii. Endorsed by the Hawaii Department of Health, the University of Hawaii School of Public Health, and the *Honolulu Star-Bulletin*, its members reviewed medical literature, heard testimony from leprologists, and deliberated over a period of five months before making recommendations on policy for the treatment of leprosy in Hawaii.

STATUS OF LEPROSY IN HAWAII*

The number of new cases of leprosy diagnosed in Hawaii has fallen to 15 or 16 per year (Fig. 1). The incidence among the native born as well as the foreign born decreased until 1961, when incidence in the immigrant population began to increase (Fig. 2). Of all patients newly diagnosed since 1946, 40 per cent had the tuberculoid form of leprosy, 22 per cent the intermediate form, and 38 per cent the lepromatous form; 41.7 per cent were granted immediate temporary release and 58.3 per cent were hospitalized (Fig. 3). Of all patients newly diagnosed since 1946, 59.4 per cent were native born and 40.6 per cent were foreign born. Of all patients newly diagnosed since 1948, 51.4 per cent were unaware of contact with another case; among the foreign born 70.7 per cent were unaware of contact; and among the native born 33.0 per cent were unaware of contact with another case.

Of all patients newly diagnosed, hospitalized, and released since 1946, the median duration of hospitalization was 3.4 years. In other words, 50 per cent remained under hospital treatment 3.4 years after admission (Fig. 4). The median duration of hospitalization for lepromatous patients was 6.4 years. Of all patients eligible for release

* From data provided by the Executive Officer, Division of Communicable Disease, Department of Health, State of Hawaii.

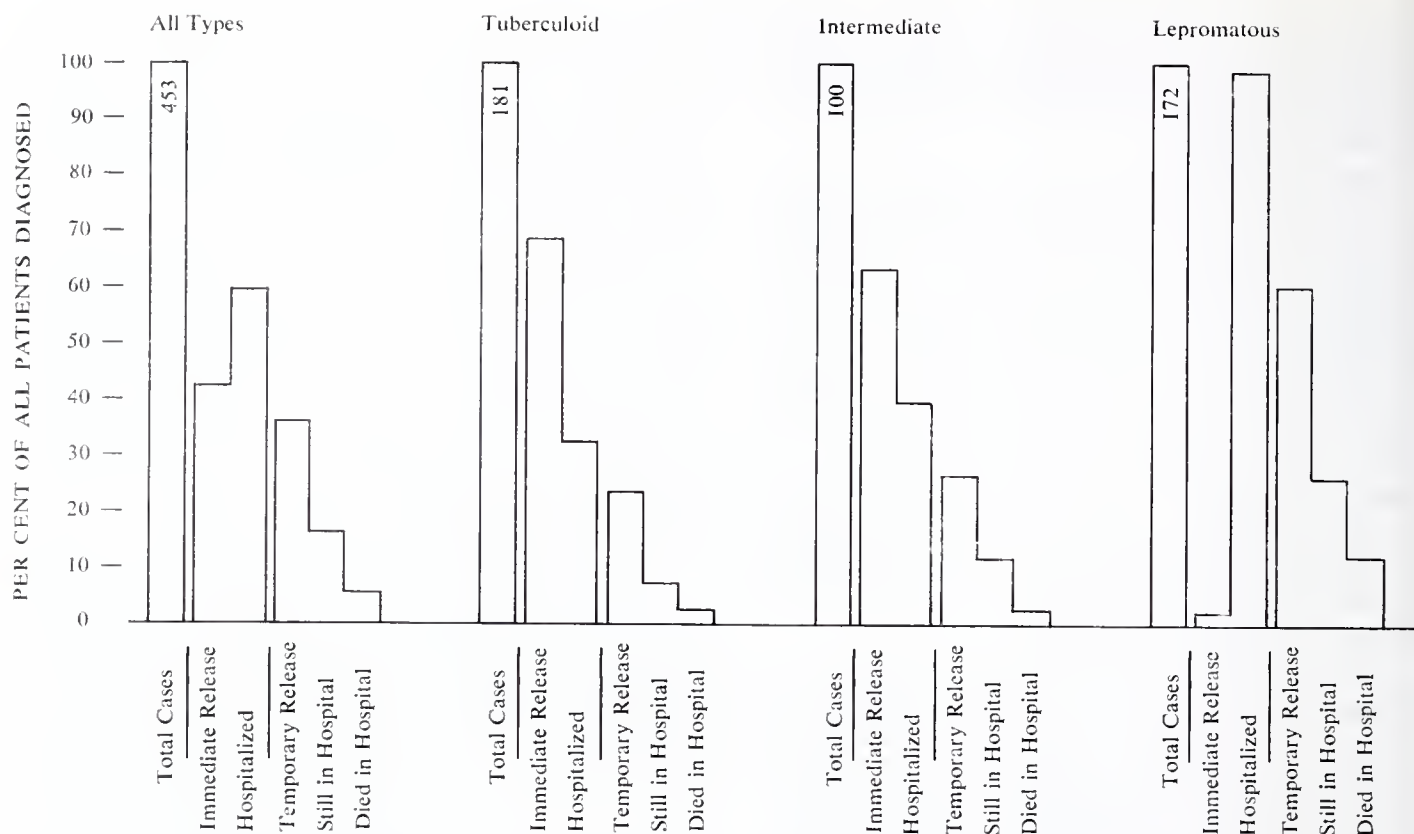


FIG. 3.—Disposition of patients with leprosy who were first diagnosed between January, 1946, and November, 1968.

from Hale Mohalu on Oahu since 1950, 95.8 per cent elected to return to the community, whereas from Kalaupapa Settlement only 5.3 per cent elected to return to the community, the balance, 94.7 per cent, remaining at Kalaupapa.

As of December 31, 1968, there were a total of 362 cases registered* in Hawaii and distributed as follows:

	INACTIVE	ACTIVE	TOTAL
OUTPATIENTS	115	....	115
Hale Mohalu inpatients	3	71	74
Kalaupapa inpatients	121	52	173
Total	239	123	362

The average number of household contacts requiring follow-up has been six contacts per case. The total number of contacts registered is about 950. About 40 per cent of these are contacts of tuberculoid cases and about 60 per cent of other cases. The number of new contacts added per year about equals the number dropped from follow-up per year, so that the total number remains unchanged.

DELIBERATIONS ON THE RISK OF TRANSMISSION

Other variables being constant, the risk of transmission is related to lepromatous leprosy^{4, 16-22} and thus to the number of bacteria in a patient's skin which appear uniform and solid on acid-fast

staining,^{23-29, 50-52} hereafter called solid-staining bacteria. Among others,^{23, 25, 28, 29, 50-52} Shepard particularly^{24, 26, 27} has shown that infectivity of leprosy bacteria correlates with the proportion of bacteria which appear solidly and uniformly stained out of all those present in a patient's skin. His data show that when the per cent of solid-staining bacteria is high, infectivity is relatively great, and when the per cent of solid-staining forms is low, infectivity is low or absent. This fact is the basis for present regulations in Hawaii, by which patients without solid-staining bacteria are treated as outpatients. It is also the basis for discharging hospitalized patients whose solid count falls to zero per cent.

However, at low levels the solid-ratio examination may be inaccurate. In Hawaii, the difference between zero per cent and five per cent or five per cent and ten percent is often due to an actual difference of only two or three organisms among those counted, differences that could occur by chance alone. In addition, the per cent of solid forms at one spot in a patient's skin may be much different from the per cent of solid forms at a different spot in the same patient's skin. Values from zero per cent to 15 per cent, or more, may be obtained by randomly selecting a different spot for examination. Thus, there is no single value of per cent solid forms which is representative of the patient. Furthermore, the technique for measuring the solid ratio in this State is not standardized with

* Registration as active or inactive here refers to the legal status of the patient, not to clinical activity or treatment status.

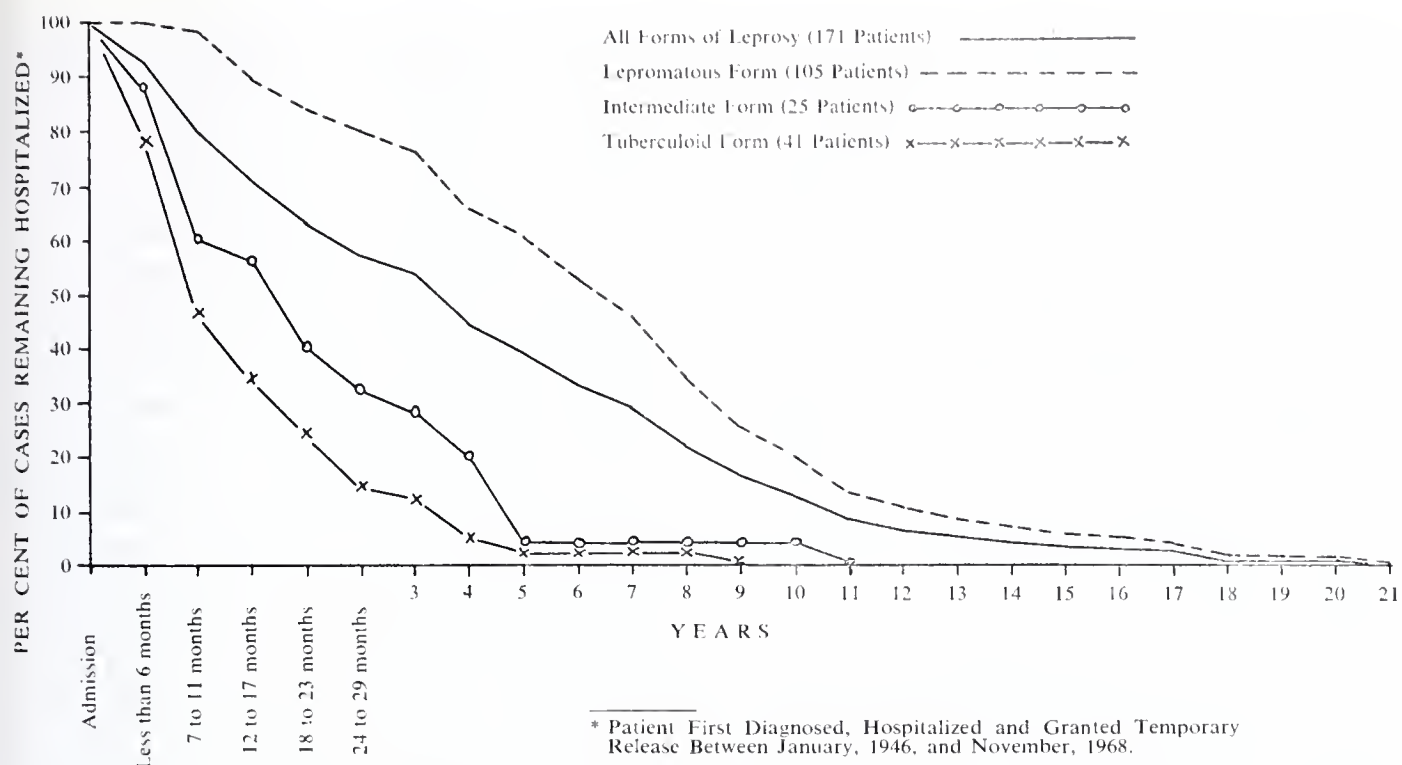


FIG. 4.—Proportion of patients with leprosy remaining under hospital treatment at various periods after admission.

direct measurements of viability determined by mouse footpad inoculation. Although the solid-ratio examination is a useful guide in medical management, these variables present problems of interpretation from a legal point of view under a policy of mandatory isolation.

Within a group of contacts of the same age, race, and type of contact, the risk of transmission is proportional to the duration of contact with a lepromatous case, in Hawaii^{4, 16} as well as elsewhere.¹⁷⁻²¹ For contacts (all ages and both sexes) of lepromatous patients in Hawaii this rate is approximately 1.5 secondary cases per 100 person-years exposure before diagnosis with treatment.¹⁶ This figure is the same as 15 cases per 1,000 person-years of exposure to a lepromatous case before his diagnosis with treatment. It is similar to the rates found elsewhere.¹⁷⁻²¹ In general, the risk of transmission or communicability is maximum prior to initial diagnosis and treatment.^{19, 24, 30, 31-35} After treatment is started this risk decreases markedly. The period between onset of symptoms and initial diagnosis with therapy is usually about six months in Hawaii^{36, 37} as opposed to one and a half to three years on the mainland.³⁸ Thus, even with complete isolation, secondary transmission may occur due to contact with undiagnosed cases. Certainly transmission has persisted in Hawaii, in spite of relatively early diagnosis and isolation of cases.

The rate of decline in communicability or infectivity after the beginning of therapy is a subject of considerable importance. There are three basic

methods of evaluating this rate of decline: the fall in the absolute number of leprosy bacteria in a patient's skin, the fall in per cent solid-staining forms, and the fall in infectivity as measured by mouse foot pad inoculation.

Generally the absolute number of leprosy bacteria, or the bacterial index, falls very slowly over a period of years after the beginning of successful therapy.^{28, 29, 32, 39, 47} Until August, 1968, the regulations of Hawaii required the complete absence of bacteria in a patient's skin as a criterion for his release. Because of this criterion, the duration of hospitalization in the past is an accurate reflection of the time required for all bacteria to disappear from a patient's skin. These data for Hawaii are seen in Figure 4.

The per cent solid-staining forms, or "solid ratio," usually falls to low levels over a period of a few months.^{24, 28, 29, 39, 50-52} For example: Waters, Rees, and Valentine^{28, 29, 39} reported that the solid ratio averaged one-fourth of the pretherapy level at three months of therapy and one-twelfth of the pretherapy level at six months. Shepard also found a marked fall in solid-staining forms after three months of therapy.²⁴

Direct measurements of declining infectivity after beginning therapy were made by Shepard.²⁴ He determined infectivity directly by mouse footpad inoculation and demonstrated that "the infectiousness (of human cases) for mice decreased in the first 30 days and was only barely detectable at 30 to 90 days, after which it was not detectable. . . . The total number of bacilli in the skin of pa-

tients decreased much more slowly during the period of observation (the first 300 to 400 days of treatment)."

There is an important difference between viability of leprosy bacteria in a patient and the transmissibility of that patient's disease. Viability refers to the capacity of leprosy bacteria to reproduce and is measured under special, standardized laboratory conditions designed to support and encourage the reproduction of leprosy bacteria. The measurement of viability is a complex research procedure, not a routine clinical tool. Transmissibility refers to the risk of developing disease among persons having contact with a lepromatous patient. As discussed above, transmission depends on complex factors such as susceptibility, type of leprosy, duration of contact, etc.

A patient with no viable bacteria obviously cannot transmit the disease. However, a patient with viable bacteria is not necessarily capable of transmitting the disease. There is no question that viable bacteria may remain in a patient's skin for months or years after "successful" therapy and can lead to a full-blown recurrence of disease upon withdrawal of drugs. However, this potential for reactivation* is not the same as the potential for transmission of disease; the potential for reactivation may be present with no risk of transmission. This situation is similar to that in human tuberculosis, where bacilli in the lungs or lymph nodes may lead to reactivation of disease years after initial successful therapy. As is well known in tuberculosis, such persons are noninfectious while their disease is inactive, even though they may have the potential for reactivation. In Hawaii to date, among all patients with leprosy who were first diagnosed, hospitalized (isolated), and released between 1946 and 1968 with at least three smears showing no bacteria, the relapse or reactivation rate was 23.3 per cent. Thus, isolation is not a treatment, and does not alter the potential for relapse in a patient who has had an initial response to therapy.

Limited epidemiologic data support these conclusions on infectivity based on these laboratory findings. In a study by Worth³⁰ and in data reported by Brown⁴⁰ there were no cases of leprosy among children born to lepromatous parents on therapy at home. Figueredo¹⁹ reported that incidence in children living with cases under treatment was one-third of that seen in children living with inadequately treated, or untreated cases. Since there was pretherapy contact, secondary cases were not entirely eliminated from the children living

with cases under adequate treatment. Incidence in the relatively circumscribed population of Hong Kong has continued to drop since the elimination of isolation as a control measure in 1954.³² Based on past experience in Hawaii and some rather conservative estimates, the author has calculated that, for a Hawaii resident, under a policy of brief hospitalization and appropriate prophylactic measures, the maximal additional risk of contracting leprosy over the present isolation policy would be about one chance in 8,000,000 per year. The probable actual risk would be even lower. From a statistical point of view, this risk is too small to be empirically measured in this state. For comparison purposes, the risk of developing paralytic complications due to oral polio vaccine is approximately one chance in 3,000,000⁴⁸—and vaccination against polio is considered an essential part of good preventive medicine in Hawaii. Thus, a patient established and maintained on therapy poses no threat to the public health, even if there are some viable bacteria in his skin. The social and psychological disruption of patients resulting from prolonged hospital isolation greatly outweighs the small risk of developing secondary cases from lepromatous cases treated as outpatients.

Prophylaxis is used to prevent disease in household members having contact with a lepromatous patient before his diagnosis with therapy. BCG vaccination has been reported as effective in protecting household contacts of cases.^{40-42, 49} However, there is some controversy as to how effective BCG vaccination has been.⁴³ Drug prophylaxis is relatively effective.^{34, 41, 43, 44, 45} An intramuscular long-lasting sulfone (DADDS, a drug not yet licensed in the U.S.) appears to be particularly promising for treatment of contacts and cases.^{34, 46}

Patients with erythema nodosum leprosum (ENL)* reactions are management problems because of their allergy to the cellular debris of dead bacteria that result from effective therapy.¹⁸ However, this complication in no way negates the desirability of a program of brief hospitalization and outpatient therapy; it rather adds additional problems, which can usually be controlled. From a public health point of view such patients can be managed either inside or outside a hospital. From a medical point of view, it may be desirable to hospitalize these patients for treatment, but not for isolation.

CONCLUSIONS OF THE HAWAII COMMITTEE ON LEPROSY

In general, without consideration of the circumstances in any particular geographic area, the prin-

* Reactivation is a recurrence of activity of the disease itself. This condition is distinct from a reaction, which is an allergic response to leprosy bacteria or debris of dead bacteria and does not imply recurrence of the disease itself.

* An ENL reaction is a severe allergic response of a patient to leprosy bacteria or debris of dead bacteria and does not imply reactivation of the disease itself.

ciples for the management of leprosy can be summarized as follows. Once adequate treatment has been established and is maintained by outpatient supervision, leprosy patients pose no risk to the public health. Under such conditions, isolation either in a hospital or at home is not a desirable public health measure with the present availability of effective drugs. However, patients may need hospitalization on a voluntary basis for medical reasons, or for problems requiring special inpatient services, such as a need for reparative or rehabilitative procedures. Either a general medical ward or a special facility for leprosy is acceptable for such patients from a public health point of view.

However, the potential social problems arising from outpatient therapy or from admission to a general hospital in certain areas, and the availability of physicians experienced in leprosy, should be considered in selecting the type of facility for the care of patients with this disease. The medical and rehabilitation problems associated with leprosy should be handled as part of a general public health program for chronic diseases. Laboratory measurements of the per cent of solid-staining forms are useful as a guide in evaluating response to therapy but are not a reliable measure of infectiousness unless standardized with direct measurements of viability in experimental mice. Special disinfection of mail, clothes, linens, or other soiled articles is unnecessary. Household contacts of lepomatous cases should be investigated and treated prophylactically with drugs or BCG vaccine, or both. Isolation facilities or special precautions are unnecessary for travel on public carriers by patients maintained on therapy. Legally enforced separation of a newborn from an infected mother, once she is established and maintained on therapy, is not a necessary or desirable control measure. However, a separation of several months, until therapy is established, may be advisable if acceptable to the mother and to the physician on a voluntary basis. Physician education and outpatient education are crucial elements in control and treatment. For this reason, training should be an integral part of any program, particularly for outpatients.

The term "Hansen's Disease" in place of leprosy only intensifies the problem it is supposed to eliminate—a centuries-old fear of the disease. The solution to this problem is proper education of the medical and lay community, not an allegedly innocuous euphemistic term.

Based on these conclusions, the Committee on

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Leprosy made the following recommendations for Hawaii:

1. The present Public Health Laws and Regulations of Hawaii should be revised to the effect that:

a. Hospitalization of patients with leprosy should be individually determined on medical-social grounds, which would include the patient's medical condition, laboratory findings, home environment, the need for special hospital services, and other related factors as advised by the attending physician; laboratory results should not in practice be the primary criterion for admission or discharge.

b. The legal authority to enforce hospitalization should reside in the general police powers* of the Health Department, not in legislation specific for leprosy.

c. Hospitalization should be voluntary for medical reasons in the sense that the general police powers of the Health Department be invoked only for individuals whose refusal to cooperate with medical management constitutes a threat to the public health. Routine isolation is not a desirable public health measure for patients who are established and maintained on therapy and who have no complication which threatens the public health. Therefore, hospitalization of such patients should not be enforced by legal means. A patient who has maintained adequate therapy under outpatient supervision by a physician and who has not had complicating factors threatening the public health could be advised to enter or to remain in a hospital for his own benefit, but this recommendation should not be enforced by the general police powers of the Health Department.

2. Facilities for the comprehensive treatment of leprosy should be established in close proximity to the University of Hawaii Medical School. This facility should be physically structured and staffed in such a way that the patients will be able to identify with a familiar place and with familiar people, attuned to their special needs. This will provide an atmosphere which will benefit patients and staff, as well as assist in training physicians who are crucial to effective control, treatment, and educated public opinion. This facility should remain under the administrative, medical, and fiscal control of the Hawaii Health Department. Expanded outpatient and rehabilitation services should be included.

3. The following should be the program of the Department of Health:

a. Hospitalization voluntary as defined above and strongly encouraged when indicated. Patients with relapsed or reactivated leprosy will be hospitalized under the same criteria as newly diagnosed patients.

* Chapter 49, Revised Laws of Hawaii, 1955.

b. Patients at the comprehensive leprosy care facility will be recommended for discharge from the hospital to outpatient therapy as soon as the physician in charge recommends it. It is recognized that some patients may require special inpatient care for medical, social, vocational, or rehabilitation reasons.

c. The outpatient program will place special emphasis on education and motivation aimed at keeping patients on therapy and under medical supervision. Patients will be treated until they become bacteriologically negative and will continue therapy thereafter for as long as necessary in the judgment of the responsible physician. In all instances the treatment regimen will be individualized for each patient. For patients with residual deformities of leprosy, outpatient status will continue until all corrective and rehabilitative measures have been exhausted.

d. Outpatients may be admitted temporarily for hospital care of complications of leprosy either to general hospitals or to the comprehensive leprosy care facility.

e. Contacts of diagnosed patients will be examined through the outpatient services of the program. These examinations will be made on diagnosis of the patient and as often thereafter as necessary in the judgment of the attending physician. Contacts will include other members of the same household that are probably at risk from exposure to a case. All methods of protecting contacts through some form of prophylaxis will be utilized.

4. All avenues should be explored to coordinate and standardize laboratory techniques with the National Communicable Disease Center in Atlanta, Georgia. The only direct, accurate measurements of viability are those using the mouse footpad technique as performed at the NCDC and at the USPHS Hospital in San Francisco. These direct measurements of viability have been correlated with solid-staining forms in those laboratories, and the measurement of the solid ratio as performed there is an accurate reflection of viability. Standardization of methods with those used at NCDC will permit the direct application of considerable special knowledge to patients in Hawaii, not otherwise directly applicable. A standardized technique will be useful in evaluating patients apparently resistant to therapy.

5. The following recommendations are made regarding Kalaupapa:

a. That persons currently hospitalized at Hale Mohalu for leprosy may continue to transfer to Kalaupapa on the same voluntary basis that has been in effect since 1955.

b. That any newly diagnosed patients and current outpatients, upon adoption of these recom-

mendations, be permitted to transfer to Kalaupapa only with the approval of the Director of Health.

c. That the Department of Health should develop methods and incentives to encourage people at Hale Mohalu who are considering transfer to Kalaupapa, to remain for treatment at the comprehensive leprosy care facility. Such incentives should be at least equal to the rights, privileges, and perquisites at Kalaupapa.

d. That the Department of Health develop methods and incentives to encourage residents of Kalaupapa to return to the community whenever possible, without jeopardizing their legal rights, privileges, and perquisites at Kalaupapa.

6. The Department of Health, with patient participation, should consider the best utilization of the land of the county of Kalawao; and should any of the land be used for any purpose other than care of leprosy patients, the care and privileges of the patients should not be jeopardized.

7. The Department of Health, with patient participation, should study the laws of Hawaii pertaining to leprosy and pursue legislative action so that the laws will become consistent with the recommendations herein contained and so that the rights, privileges, and perquisites of patients will be protected.

8. The Department of Health should develop a comprehensive rehabilitation program and develop funding through public and private sources. Such funds may be used for physical and surgical rehabilitation, financial support, assistance in finding housing and employment, and education of employers and family members. Should private funds become available the Health Department should cooperate with the donor agency in finding the best means of using the funds on behalf of the patients.

9. There should be an intensive education program for the professional and lay community. Recognizing that the stigma of leprosy must be removed, the Department of Health, through its Health Education office, should use every educational method and technique in bringing correct information to the community.

10. Periodic refresher courses for physicians should be required after licensure to insure that physicians will be kept abreast of current medical knowledge and thereby insure their ability to make an early diagnosis of leprosy.

COMMITTEE ON LEPROSY

Chairman: Thomas K. Hitch, Ph.D.

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Ex Officio: Ira D. Hirschy, M.D., Lee Wheeler.

In summary, the basis for changing isolation policy in Hawaii is (a) effective treatment and prophylaxis for leprosy, (b) direct experimental evidence of a rapid decline in infectivity of leprosy bacteria after beginning a patient on therapy, (c) relative ineffectiveness of isolation as a control measure because of pre-therapy communicability and increasing numbers of immigrant cases, (d) social-psychological problems of patients in prolonged hospital isolation, (e) epidemiologic data indicating the safety of home care, and (f) evolution of understanding and attitudes of the community, so that a change was not only possible but actively pursued by important organizations in the State such as the Department of Health, the Hawaii Medical Association, the Honolulu Star-Bulletin, and the University of Hawaii School of Public Health and Medical School.

The decisions of this committee are of little practical significance outside Hawaii, and obviously the problems of patients with leprosy remain. However, these decisions, made in a former bastion of the isolation approach, are a step toward the day when a patient with leprosy will be nothing more than an average citizen with a disease needing medical treatment and possibly a brief, voluntary hospitalization.

REFERENCES

1. Hirschy, I. D.: 100 years at Kalaupapa, Hawaii Health Messenger, Vol. 20, No. 2, 1965. Also Annual Statistical Report, Department of Health, State of Hawaii, 1966, p. 80.
2. Chung-Hoon, E. K.: Leprosy in Hawaii, Parts I and II, HAWAII MED. J. 1:39-40, 41 (Sept.) 1941.
3. Sloan, N. R.: Early diagnosis of leprosy, HAWAII MED. J. 3:111-120 (Jan.-Feb.) 1944.
4. Worth, R. M.: Leprosy in children born at Kalaupapa, HAWAII MED. J. 19:403-406 (Mar.-Apr.) 1960.
5. Cochrane, R. G.: The history of leprosy and its spread throughout the world in leprosy in theory and practice, Ed. Cochrane and Davey, 2nd ed., Baltimore, The Williams and Wilkins Company, 1964, pp. 7-10.
6. From data prepared on December 29, 1949, and on March 8, 1951, by the Office of Research, Planning, and Statistics, Department of Health, State of Hawaii.
7. Myerson, J. A.: Depopulation among the native Hawaiians. Thesis for M.A. prepared June, 1953, page 131, Table 7.
8. References to Leprosy in the Laws of Hawaii prepared by Bernard Punikaia and I. D. Hirschy for the Committee on Leprosy, 1969.
9. The Molokai Settlement, Territory of Hawaii, Board of Health, Pub. Hawaii Gazette Co., Ltd., 1907, pp. 10-13. Also see Report of the President of the Board of Health, Territory of Hawaii, December 31, 1902, The Bulletin Pub. Co., Honolulu, 1903, p.13.
10. Laws of the Territory of Hawaii, Regular Session of 1911, p.158, Act 113, Section 1. Also see Revised Laws of Hawaii, 1915, p.486, Section 1100 and Section 1103.
11. Session Laws of Hawaii, 1929, p.163-164, Act 149, Section 1. Also see Revised Laws of Hawaii, 1935, p.215, Section 1148 and Section 1154.
12. Faget, G. H., Johansen, F. A., Dinan, J. F., Prejean, B. M., Eccles, C. G.: The promin treatment of leprosy: A progress report, Public Health Rep. 58:1729-1741 (Nov.) 1943.
13. Personal letter, I. D. Hirschy to E. K. Chung-Hoon, dated Dec. 27, 1966.
14. Hirschy, I. D.: Proposed changes in the Hansen's Disease Program for Hawaii, Memoranda dated Feb. 28, 1968.
15. Public Health Regulations, Department of Health, State of Hawaii, Chapter 27, Section 3, August 3, 1968.

16. Worth, R. M., Hirschy, I. D.: A test of infectivity of tuberculo-leprosy patients, HAWAII MED. J. 24:116-119 (Nov.-Dec.) 1964.
17. Guito, R. S., Doull, J. A., Bancroft, H., Rodrigues, J. N.: A field study of leprosy in Cordova, Philippines, Int. Jour. Leprosy 19:117-135 (Apr.-June) 1951.
18. Skinsnes, O. K.: The immunologic spectrum of leprosy in leprosy in theory and practice, Ed. Cochrane and Davey, ed. 2, Baltimore, The Williams and Wilkins Co., 1964, pp. 156-182.
19. Figueredo, N., Balkrishnan, V.: Risk of infection in leprosy, Leprosy Review 38:87-96 (Apr.) 1967.
20. Doull, J. A.: The epidemiology of leprosy, Int. J. Leprosy 30:48-66 (Jan.-Mar.) 1962.
21. Newell, K. W.: An epidemiologist's view of leprosy, Bull. WHO 34:827-857, 1966.
22. Bancroft, H., Guito, R. S., Rodriguez, J. W., Marques, A. P.: A note on the familial relationship and the risk of developing leprosy, Int. J. Leprosy 12:79-82 (Dec.) 1944.
23. McFadzean, J. A., and Valentine, R. C.: The examination and the determination of the viability of mycobacterium leprae by electron microscopy, Leprosy Rev. 31:6-11 (Jan.) 1960.
24. Shepard, C. C., Levy, L., Fasal, P.: The death of mycobacterium leprae during treatment with DDS, Amer. J. Trop. Med. 17:769-775 (Sept.) 1968.
25. Levy, L., Shepard, C. C., Fasal, P.: Correlation of the solid ratio of mycobacterium leprae in clinical specimens with the results of mouse foot pad inoculation. (Abstract).
26. Shepard, C. C., McRae, D. H.: Mycobacterium in mice: Minimal infectious dose, relationship between staining quality and infectivity, and effect of cortisone, J. Bact. 89:365-373 (Feb.) 1965.
27. Shepard, C. C., Chang, Y. T.: Effect of DDS on established infections with mycobacterium leprae in mice, Int. J. Leprosy 35:52-57 (Jan.-Mar.) 1967.
28. Rees, R. J. W., Valentine, R. C.: The appearance of dead leprosy bacilli by light and electron microscopy, Int. J. Leprosy 30:1-9 (Jan.-Mar.) 1962; also in the submicroscopical structure of the mycobacterium leprae in leprosy in theory and practice, Ed. Cochrane, and Davey, ed. 2, Baltimore, The Williams and Wilkins Company, 1964, pp. 26-35.
29. Waters, M. F. R., Rees, R. J. W.: Changes in the morphology of mycobacterium leprae in patients under treatment, Int. J. Leprosy 30:266-277 (July-Sept.) 1962.
30. Worth, R. M.: Is it safe to treat the lepromatous patient at home, Int. J. Leprosy 36:296-302 (July-Sept.) 1968.
31. Testimony presented to the Committee on Hansen's Disease by Dr. Paul Fasal on December 16, 1968.
32. Testimony presented to the Committee on Hansen's Disease by Dr. Olaf Skinsnes on November 21, 1968.
33. Testimony presented to the Committee on Hansen's Disease by Dr. Roger A. Feldman on January 16, 1968.
34. Testimony presented to the Committee on Hansen's Disease by Dr. Norman R. Sloan on January 8, 1969. (Manuscript in preparation.)
35. Testimony presented to the Committee on Hansen's Disease by Dr. John R. Trautman on January 23, 1969.
36. Personal communication from I. D. Hirschy, M.D.
37. Chung-Hoon, E. K., Hedgecock, G.: Racial aspects of leprosy and recent therapeutic advances, HAWAII MED. J. 16:125-130 (Nov.-Dec.) 1956.
38. Brubaker, M. L.: Epidemiology of leprosy and a Carville study in selected papers on leprosy, U. S. Public Health Service Hospital, Carville, Louisiana, April, 1967, Table 12, p. F-21.
39. Waters, M. F. R., Rees, R. J. W., Sutherland, I.: Chemotherapeutic trials in leprosy, Int. J. Leprosy 35:311-335, (July-Sept.) 1967.
40. Brown, J. A. K., Stone, M. M., Sutherland, I.: BCG vaccination of children against leprosy in Uganda: Results at end of second follow-up, Brit. Med. J. 1:24-27 (Jan.) 1968.
41. Fasal, P., Fasal, E., Levy, L.: Leprosy prophylaxis, JAMA 199:905-908 (Mar.) 1967.
42. Ghosh, S., Das, B. K.: Observations on the value of BCG vaccination for the prevention of leprosy. Trop. Dis. Bull. 64:508 (May) 1967.
43. BCG and Prophylaxis. Ninth International Leprosy Congress Abstracts, London, September 16-21, 1968, pp. 58-61.
44. Wardelar, R. V.: DDS prophylaxis against leprosy (abstract), Int. J. Leprosy 36:250 (April-June) 1968.
45. Dharmendra, A., Noordeen, S. K., Ramanujam, K.: Prophylactic value of DDS against leprosy—an interim report, Trop. Dis. Bull. 64:1332-1334 (Dec.) 1967, and a further report, Trop. Dis. Bull. 65:889-890 (July) 1968.
46. Shepard, C. C., Tolentino, J. G., McRae, D. H.: The therapeutic effect of DADDs in leprosy, Amer. J. Trop. Med. 17:192-201 (March) 1968.
47. Ridley, D. S.: A logarithmic index of bacilli in biopsies. 2. An evaluation. Int. J. Leprosy 35:187-193 (April-June) 1967.
48. Recommendations of the Public Health Service Advisory Committee on Immunization Practices, in Morbidity and Mortality Weekly Report, Vol. 16, No. 33 (Aug.) 1967.
49. Leiker, D. L., Otsyula, Y., DesPlantes, M. Z.: Effect of BCG vaccination on leprosy in Kenya. Leprosy Rev. 39:84-86 (April) 1968.
50. Pettit, J. H. S., Rees, R. J. W.: Chemotherapeutic trials in leprosy. 4. Dapsone (DDS) in low dosage in the treatment of leprosy. Int. J. Leprosy 35:140-148 (April-June) 1967.
51. Pettit, J. H. S., Rees, R. J. W., Ridley, D. S.: Chemotherapeutic trials in leprosy. 3. Pilot trial of a rimonphenazine derivative, B. 663, in the treatment of leprosy. Int. J. Leprosy 35:25-33 (Jan.-March) 1967.
52. Waters, M. F. R.: Significance of fragmented leprosy bacilli. Int. J. Leprosy 35:518-520 (Oct.-Dec.) 1967. ■

Multiple sclerosis is three times commoner in Caucasians than in Orientals in Hawaii.

Multiple Sclerosis in Hawaii

A Preliminary Report

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● *Caucasians outnumbered Orientals 3:1 among 40 cases of multiple sclerosis diagnosed in Hawaii from 1960 to 1968. Nine of the 11 Oriental cases had involvement of the optic nerves and spinal cord; in seven, both optic nerves were involved, simultaneously in five and successively in two. Myelitis was severe in all seven, but mild in the two with unilateral eye involvement. Optic nerve involvement occurred in only twelve of the 29 Caucasian cases.*

EPIDEMIOLOGICAL studies have shown that multiple sclerosis is much more prevalent in temperate zones than in subtropical and tropical zones. These studies have implied that geographical location plays an important role in the etiology of multiple sclerosis. However, several studies have shown the relatively low incidence of multiple sclerosis in the Japanese population^{1, 4} despite the fact that Japan is in the temperate zone (30°-40°N. latitude).

Hawaii consists of a group of eight main islands in the middle of the Pacific Ocean located between the 19° and 23° parallels of latitude. The islands lie just south of the Tropic of Cancer. There is little difference in temperature between summer and winter. Honolulu has an average temperature of 75°F. and the temperature remains fairly well between 65° and 85°.

Although no accurate figures are obtainable, it is well known in medical circles here that multiple sclerosis is a rather uncommon disease. In fact, it was unheard of in the Polynesian and Oriental races until quite recently.

In Japan, the clinical forms of multiple sclerosis are somewhat different from those reported from Europe and the United States. Previous studies by one of us (Y.K.)⁵ suggest that the optic-spinal form (with or without brainstem involvement) is more common in Japanese than in Caucasians, and that the involvement of the optic nerves in them is usually bilateral, whereas in the Caucasian population it is usually unilateral.

This paper is a preliminary survey of multiple

sclerosis in Hawaii including neuromyelitis optica (Devic's syndrome). Hawaii is a cosmopolitan state in which many racial groups live together. It was felt that a study of multiple sclerosis among the various racial groups might prove of value in an attempt to see if there are any differences in racial incidence and to see if there are any differences in the clinical forms of multiple sclerosis.

MATERIAL

Forty cases of multiple sclerosis (including neuromyelitis optica) were collected in Hawaii up to 1966. These are all clinical cases without autopsy confirmation. The majority of these (35) were seen by one of us (MMO). Five additional cases were obtained by reviewing all the recorded cases of multiple sclerosis from three general hospitals (Queen's, St. Francis, and Kuakini) for the past eight years. These three hospitals account for the great majority of the short-term hospital beds for adult patients in Honolulu, which is the largest city and the only one of significant size in Hawaii.

RESULTS

Of the forty patients, 29 were Caucasians, eight were Japanese, and three were Chinese (Table 1). Relative to the total population of Hawaii, the incidence of multiple sclerosis is greater in the Caucasian as compared to the Japanese and Chinese. Thus, 72.5 per cent of all the patients with multiple sclerosis were in Caucasians, who make up 37 per cent of the population, whereas only 28.5 per cent were in the Japanese and Chinese, who together make up 35 per cent of the population.

TABLE 1.—Multiple sclerosis in Hawaii.

RACES	M. S. PATIENTS		POPULATION OF HAWAII*	
	No. of Cases	%	Population	%
Caucasian	29	72.5	260,953	37
Japanese	8	20	207,950	29
Chinese	3	7.5	40,016	6
Others	0	0	204,327	28
Total	40	100	714,092	100

TABLE 2.—Multiple sclerosis in Japanese and Chinese patients in Hawaii.

CASE	AGE OF ONSET	SEX	RACE	CLINICAL FORM
1	21	F	Japanese	Optic spinal
2	21	F	Japanese	Optic spinal
3	27	F	Japanese	Optic spinal or Devic's
4	37	F	Japanese	Optic spinal
5	40	F	Japanese	Optic spinal or Devic's
6	30	F	Japanese	Optic spinal
7	50	M	Japanese	Optic spinal
8	31	M	Japanese	Spinal
9	22	M	Chinese	Optic spinal
10	17	F	Chinese	Optic spinal or Devic's
11	38	M	Chinese	Spinal

Strangely enough, no cases of multiple sclerosis were seen in the Hawaiian or Filipino races, which together make up approximately 25 per cent of the population.†

Of the eleven Japanese and Chinese patients there were eight women and three men (Table 2). The average age at the onset of the first symptoms of multiple sclerosis was 27 years in the women and 39 years in the men.

All eleven patients of Japanese and Chinese ancestry were born in Hawaii, while only a fifth of the Caucasian patients (6 out of 29) were born in Hawaii. Although three of the Oriental patients spent a significant number of years in the mainland United States, only one developed the first symptom of multiple sclerosis while away from Hawaii. On the other hand, in the Caucasian group, two-thirds (18 patients) had had their first symptom suggestive of multiple sclerosis before coming to Hawaii from the mainland.

In the 29 Caucasian patients, twelve had involvement of the optic nerves and spinal cord. However, only two had bilateral optic nerve involvement and seven had significant signs and symptoms of brainstem and cerebral involvement.

Of the 11 cases in the Japanese and Chinese, nine had involvement of the optic nerves and spinal cord (Table 3). The other two had only spinal cord involvement. Seven of the nine had both optic nerves involved.

CASE HISTORIES

CASE 1.—A 34-year-old Japanese housewife, mother of two children, was born and raised in Hawaii. At age 21 (1953) she had sudden onset of blindness, which lasted for three or four weeks. In May, 1958, approximately ten days after the delivery of her first child, in Bremerton, Washington, she developed urinary incontinence and numbness and weakness of her legs. Examination at that time showed a paraparesis with a sensory

† Since writing this paper, I have reviewed the case history of a Filipino patient with classical signs and symptoms of multiple sclerosis.

TABLE 3.—Relationship of Optic Nerve and Spinal Cord Lesions in Japanese and Chinese Cases.

OPTIC LESION	NO. OF CASES		
	Simult. bilateral	Successive bil.	Unilateral
Marked myelitis Paraplegia	5	2	—
Moderate myelitis Partial cord sign	—	—	1
Minor myelitis	—	—	1

level at T5. The deep tendon reflexes in the legs were hyperactive, with bilateral Babinski signs. Spinal fluid findings were normal except for an abnormal first zone gold curve. Over a period of a month, her symptoms gradually subsided.

In 1961, after the birth of the second child, she again developed numbness and weakness of her lower extremities and urinary incontinence. She was given a course of intravenous histamine. In September, 1963, a tubal ligation was done. About a month later, she began to have numbness and weakness of all four extremities accompanied by a severe headache and fever. Spinal fluid examination, at that time, revealed a spinal fluid protein of 96 mg/ 100 ml; two days later it was reported as 300, with 34 lymphocytes and 13 polymorphonuclear cells in the spinal fluid. Bilateral carotid angiograms and pneumoencephalograms were normal. The patient was treated conservatively, but subsequent examinations always showed residual neurological deficits.

In the summer of 1964, she returned to Hawaii as a wheelchair patient. Shortly after that, she was able to walk with crutches. In December, 1964, she developed weakness and numbness of the right arm as well as both legs. She had been taking steroids since her return to Hawaii, and at the time of examination appeared Cushingoid. No nystagmus was noted. The optic discs were pale. She demonstrated quadriparesis with marked weakness in both legs, moderate weakness in the right arm, and slight weakness in the left arm. Deep tendon reflexes were all hyperactive, with bilateral extensor plantar signs. A small decubitus was noted over the sacrum, and a healed decubitus on the right ankle. She had a sensory level at T3, but there was also some loss of two-point sensation and stereognosis in both hands. She was treated conservatively and did well and in April, 1965, was able to get along at home with one crutch. In June, 1965, her legs gave way and she had difficulty in walking. The right leg especially was markedly weak and she developed a small decubitus over the sacrum. She was given a course of prednisone, and subsequently did well.

On October 22, 1965, spinal fluid immunoelectrophoretic study showed "a very strong reaction of gamma-G; there is a distinct line of precipitin reaction, as gamma 2-2." At the present time the patient is doing fairly well, walking with crutches and managing her household duties, including the care of her two children, with little outside help.

CASE 2.—A 39-year-old Japanese woman first seen on October 17, 1962, born and raised in Hawaii, had been well until the end of her third pregnancy in 1946, when she had the sudden onset of complete loss of vision. Three years later, she developed numbness and weakness of the left leg. However, she improved and was able to walk until 1952, when she suffered a fall. Following this, she was unable to walk, and developed numbness and weakness of both arms. The symptoms in her arms cleared completely but the numbness and weakness of her legs did not.

At the time of the examination, she was completely blind; she could not even perceive light. Her pupils were dilated and did not react to light; they did react in accommodation, however. Both optic discs were very pale. Examination of her upper extremities was normal. The abdominal reflexes were absent. In the lower extremities, she had a mild flexion contracture of her hips. The knees could be extended completely, but she had a tight right heel cord. Both feet were held in a slightly equinovarus position. There was spasticity and moderately severe weakness of both legs. The knee jerks were slightly hyperactive and the ankle jerks appeared normal. She had bilateral Babinski signs, more marked on the left. Vibratory and position sensations were absent in both lower extremities. She was able to feel light touch but it was diminished up to the level of T7 bilaterally. She could feel pinprick fairly normally in her legs. She had a spastic bladder, with urge incontinence.

She has been in a chronic care home ever since, with no further changes in her neurological picture.

DISCUSSION

Because of the interesting geographical distribution of multiple sclerosis in the world, exogenous factors, such as climatic conditions, have been implicated in the pathogenesis of the disease. Although the total number of patients is rather small, our figures in this preliminary study in Hawaii indicate an approximate three-fold incidence of multiple sclerosis in the Caucasian race as compared to Orientals. Part of this could be explained by the fact that most of the Caucasians came from the North American continent, whereas all of the Japanese and Chinese were born and raised in Hawaii.

In the Japanese and Chinese, the optic nerves and spinal cord were most commonly involved. Furthermore, bilateral simultaneous involvement of both optic nerves as seen in neuromyelitis optica was rather frequent. A similar tendency has been reported in Japan.⁵ In Korea, the spinal form of multiple sclerosis is said to be most common.⁷ Pathological studies have demonstrated the severe demyelinating processes in the optic nerves and spinal cords in the cases from Japan.⁸ The vulnerability of the optic nerves is evidently different from that of the usual case of multiple sclerosis in the Western Hemisphere.

Again, although the figures are rather small, there appears to be a basic similarity in the clinical forms of multiple sclerosis in the Orientals from Hawaii and in the cases seen in Japan. This would imply that constitutional factors may exist which influence the frequency and forms of this disease.

SUMMARY

Clinical cases of multiple sclerosis in the Hawaiian population were surveyed, utilizing both clinic outpatients and hospital inpatients.

The incidence of multiple sclerosis is significantly (approximately three-fold) higher in the Caucasians as compared to the Orientals (Japanese and Chinese).

In the Orientals, multiple sclerosis most frequently involves the optic nerves and spinal cord. Often the clinical picture of neuromyelitis optica (Devic's syndrome) is seen.

While the importance of geographic factors and other hitherto unknown factors cannot be denied, constitutional factors may exist and influence the clinical forms of the disease.

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REFERENCES

1. Okinaka, S., Tsubaki, T., Kuroiwa, Y., Toyokura, Y., Imamura, Y., and Yoshikawa, M.: Multiple sclerosis and allied diseases in Japan; clinical characteristics, *Neurology* 8:756-763 (Oct.) 1958.
2. Okinaka, S., McAlpine, D., Miyagawa, K., Suwa, N., Kuroiwa, Y., Shiraki, H., Araki, S., and Kurland, L. T.: Multiple sclerosis in Northern and Southern Japan, *World Neurol.* 1:22-24 (July) 1960.
3. Okinaka, S., Reese, H., Katsuki, S., et al: The prevalence of multiple sclerosis and other neurological diseases in Japan, *Acta Neurol. Scand. Suppl.* 19, *Studies in Multiple Sclerosis IV*, 42:68-76, 1966.
4. Okinaka, S., and Kuroiwa, Y.: Multiple sclerosis and allied disease in Japan; Epidemiological and clinical aspects. *Progress in Brain Research* 21 B. *Correlative Neurosciences part B: Clinical Studies* 183-191, 1966. Elsevier Publ. Co., Amsterdam.
5. Kuroiwa, Y., Araki, S., and Katsuki, S.: Clinical features of demyelinating diseases in Japan, *Proc. 8th International Congress of Neurology, Vienna, September, 1965*, IV:83-86.
6. Kurland, L. T., and Reed, D.: Geographic and climatic aspects of multiple sclerosis. A review of current hypotheses, *Amer. J. Publ. Health* 54:588-597 (Apr.) 1964.
7. Park, C. S.: Multiple sclerosis in Korea, *Neurology* 16:919-926 (Sept.) 1966.
8. Shiraki, H.: The concept of demyelinating encephalomyelitis with special reference to the autopsy cases in the Japanese, *Clin. Neurol.* 6:629, 1966. ■

*Immunoglobulin levels are compared in 157 cases
of four different diseases and in 1,451 normal persons.*

Immunoglobulin Levels in Diseases

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● *Blood levels of immunoglobulin G (gamma globulin: IgG) change with age, but not significantly. They are higher in cord serum than in the mother's. IgA, not detectable in the newborn, is plentiful by age three and increases with age. IgM is very low in cord serum, and though it increases with age, it is decreased again in the age 45-65 group. In myocardial infarction, IgG is below normal levels for the age group; in hyperthyroidism, it is elevated. Levels in gastric cancer and multiple sclerosis are normal.*

THE LEVEL OF immunoglobulins in the serum of man does not remain the same throughout his lifetime, but varies with his physiological condition and the rate of synthesis and catabolism of immunological substances under various circumstances. However, the serum of a normal individual will reflect a unique pattern of immunoglobulin levels. Since its inception, the single radial immunodiffusion technique¹ has proved to be a simple and rapid method for semiquantitative determinations of immunoglobulin levels in human serum.

Utilizing the single radial immunodiffusion test, the present study aimed at determining a distribution pattern of immunoglobulin levels for different age groups of normal individuals. This determination was accomplished by determining the immunoglobulin levels in sera of clinically normal individuals from infancy to sixty years of age. Furthermore, as a corollary, a preliminary study was conducted to determine whether any specific immunoglobulin alteration in certain disease states exists. To achieve this, the serums of patients with myocardial infarction, hyperthyroidism, gastric cancer, and multiple sclerosis were studied.

MATERIALS AND METHODS

Serum samples were obtained from both a normal population and from patients with various diseases. The normal group consisted of 125 babies (sex was not given), 151 normal children (94 boys and 57 girls, ages three to fifteen) and 1,175 normal adults (1,144 men and 31 women, ages 20 to 65). Two age groups in their thirties and forties consisted of 47 men and 31 women, but the 45 to 65 year olds were all men.

Serum samples from a population one to ten years of age were taken from children, most of whom had hypertrophic tonsils. Most of the children from ten to fifteen years of age were normal.

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TABLE 2.—Immunoglobulin levels in diseased groups.

AGE	NO. OF SUBJECTS	IMMUNOGLOBULIN LEVELS (MG%)					
		IgG		IgA		IgM	
		MEAN	S.D.	MEAN	S.D.	MEAN	S.D.
Newborn (cord)	125	1140.6 ± 327.8		0		12.7 ± 5.2	
3-4 years	19	1164.7 ± 292.3		130.1 ± 32.8		60.8 ± 29.2	
5-9 "	95	1194.6 ± 405.6		146.8 ± 41.2		76.5 ± 37.4	
10-15 "	37	1270.0 ± 412.0		167.4 ± 36.9		96.3 ± 57.1	
20-29 "	39	1200.8 ± 388.2		276.6 ± 146.7		102.6 ± 43.3	
30-39 "	39	1102.0 ± 323.8		254.5 ± 93.2		112.5 ± 52.6	
45-65 "	1,097	1193.6 ± 325.2		221.0 ± 70.2		56.3 ± 31.5	
TOTAL	1,451						
Mother	125	932.9 ± 303.7		198.3 ± 84.5		106.7 ± 47.1	
Cord	125	1140.6 ± 327.8		0		12.7 ± 5.2	

Finally, 125 paired mother and cord serum samples were included in this study.

The patient groups consisted of acute myocardial infarction (16 cases: 14 men and two women, ages 31 to 80); hyperthyroidism (29 cases: four male and 25 female, ages 11 to 57); gastric cancer (74 cases: 46 men and 28 women, ages 31 to 86); and multiple sclerosis (38 cases: age and sex not given). All serum samples were stored at -20°C . prior to use.

The determination of each immunoglobulin level was performed by a single radial immunodiffusion technique. Using the serum obtained from normal individuals, pure IgG, IgA, and IgM were isolated by diethylaminoethyl (DEAE)-cellulose and Sephadex G-200 column chromatography. The purity of each fraction was tested by Ouchterlony methods.

Antisera were prepared at this laboratory by the immunization of New Zealand albino rabbits with each immunoglobulin fraction. The immune antisera were analyzed by immunoelectrophoresis to determine their purity.

A 3 per cent solution of Noble agar (Difco laboratories) in 0.01M sodium phosphate buffer, pH 7.4, was heated in a boiling water bath for approximately 30 minutes, then cooled to 56°C . Two ml of agar solution and an equal volume of antiserum (concentration predetermined by titration against normal human serum) were mixed in small test tubes in a water bath at 56°C . The molten agar solution was poured into 1" X 3" X $\frac{1}{8}$ " plastic trays (Hyland Laboratories, Los Angeles). The agar containing the antiserum was allowed to solidify at room temperature and then six wells, 2.4 mm in diameter and 11 mm apart, were made with a sharp tubular cutter. Six lambdas of each serum sample were placed in each well with a Hamilton microsyringe (Hamilton Company, Inc., Whittier, California). The trays were placed in a plastic chamber and kept moist. Diffusion of the test samples was allowed to take

place for four hours for the IgG and eighteen hours for IgA, both at room temperature. The IgM diffusion required an incubation period of twenty-four hours at 37°C .

At the end of the diffusion period the diameter of the circular precipitin pattern was measured with a Fine Scale (Fine Scale, Los Angeles) and converted into mg per cent concentrations using a standard curve plotted according to sera of known concentrations. Standard sera for the immunoglobulin levels were provided by Hyland Laboratories.

RESULTS

The mean values of each immunoglobulin level (IgG, IgA, and IgM) in the normal population are shown in Table 1. No significant variation of the IgG level was found in any age group. The level of IgA increased with age but it was not detectable in cord serum. The IgM level was very low in cord serum, and increased with age, but a marked decrease was found in the 45-to-65 age group.

Analysis of 125 paired mother and cord sera showed a significant variation in each immunoglobulin level. The mean IgG value in the mother was significantly lower than in the cord serum ($p<0.01$). The level of IgA and IgM in the mother remained within normal limits, whereas the IgA was not detectable and IgM was very low in cord serum.

Serum immunoglobulin levels in patients with various diseases are shown in Table 2. The mean value of each immunoglobulin level was within the normal range, but the level of IgG was at the lower limit in myocardial infarction patients and at the upper limit in hyperthyroidism patients. However, no significant variation of the IgG level was found in patients with gastric cancer or multiple sclerosis. No changes in the IgA level was found in any of the disease groups. The IgM level in patients with multiple sclerosis was at the upper limit of the normal range.

TABLE 2.—Immunoglobulin Levels in Diseased Groups.

GROUPS	NO. OF SUBJECTS	IgG		IgA		IgM	
		MEAN	S.D.	MEAN	S.D.	MEAN	S.D.
Myocardial infarction	16	832.5 ± 238.2		254.9 ± 113.7		74.0 ± 38.0	
Hyperthyroidism	29	1565.2 ± 362.4		320.0 ± 101.2		118.0 ± 44.2	
Gastric cancer	74	1037.7 ± 210.6		164.9 ± 66.4		62.9 ± 34.6	
Multiple sclerosis	38	1157.2 ± 283.3		239.9 ± 149.4		133.7 ± 48.9	

DISCUSSION

The single radial immunodiffusion technique is a practical method for routine determination of immunoglobulins. Using this method, Stiehm and Fudenberg² determined serum levels of immunoglobulins in health and disease in various age groups. They found that the concentration of IgG decreased rapidly after birth, from the adult level in cord serum to a low level at three months of age. The level of IgA increased slowly during infancy and childhood. IgM was detectable in small quantities in every sample of umbilical cord serum tested. In the present study, similar results were obtained in the normal age groups. It is interesting to note the low IgM level of 45-to-65 age group, and this requires further investigation.

Allansmith et al³ studied immunoglobulin levels in paired mother and cord serum and found that the IgG level in cord serum was higher than in the mother. Our study also confirmed this.

Davies and Clark⁴ reported that the amount of 7S IgG was significantly decreased in the case of myocardial infarction, and they concluded that this deficiency might be an etiologic factor in coronary artery disease. The present study also demonstrated a lower level of IgG in myocardial infarction patients, indicating that perhaps there is a relationship between IgG and myocardial infarction.

The serum of patients with hyperthyroidism often shows an activity of long-acting thyroid stimulator (LATS). LATS has been found in IgG fractions and is considered an antibody.⁵⁻⁷ The present study revealed a higher level of IgG in patients with hyperthyroidism, although it remained within the normal range. It is possible that here too an immunologic reaction may be involved in the induction of the disease.

It has been considered that an immune reaction might be involved in the induction of multiple sclerosis.⁸ However, using various methods, Kabat and his associates⁹ studied many cases of multiple sclerosis and concluded that no demonstrable change was found in the serum of the patient. In

this study no variation was found in the immunoglobulin level.

SUMMARY

Immunoglobulin levels were determined using a single radial immunodiffusion technique.

The results of the normal population were analyzed for seven age groups. No significant variation of the IgG level was found in any of the age groups. The IgA level was not detectable in the newborn but increased with age. The level of IgM was very low in cord serum, increased with age, but decreased in the 45-to-65 age group.

Analysis of the paired mother and cord samples showed that the mean value of IgG was significantly lower in the mother than in cord serum. The IgA and IgM levels in the mother showed normal values, but in the cord samples IgA was not detectable and IgM was found in very small quantities.

Myocardial infarction serum showed lower levels of IgG while hyperthyroidism demonstrated high levels of IgG. No significant change was found in patients with gastric cancer or multiple sclerosis.

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REFERENCES

1. Fahey, J. L., and McKelvey, E. M.: Quantitative determination of serum immunoglobulins in antibody-agar plates, *J. Immunol.* 94:84-90 (Jan.) 1965.
2. Stiehm, E. R., and Fudenberg, H. H.: Serum levels of immune globulins in health and disease: A survey, *Pediatrics* 37:715-727 (May) 1966.
3. Allansmith, M., McClellan, B. H., Butterworth, M., and Maloney, J. R.: The development of immunoglobulin levels in man, *J. Pediat.* 72:276-290 (Feb.) 1968.
4. Davies, D. F., and Clark, A.: A serum protein deficiency related to coronary-artery disease, *Lancet* i:29-30 (Jan.) 1965.
5. McKenzie, J. M.: Fractionation of plasma containing the long-acting thyroid stimulator, *J. Biol. Chem.* 237:3571-3572 (Nov.) 1962.
6. Kriss, J. P., Pleshakov, V., and Chien, J. R.: Isolation and identification of the long-acting thyroid stimulator and its relation to hyperthyroidism and circumscribed pretibial myxedema, *J. Clin. Endocr.* 24:1005-1028 (Oct.) 1964.
7. Meek, J. C., Jones, A. E., Lewis, U. J., and Vanderlaan, W. P.: Characterization of the long-acting thyroid stimulator of Graves' Disease, *Proc. Nat. Acad. Sci.* 52:342-349 (Aug.) 1964.
8. Paterson, P. Y.: The De Myelinating Diseases, in Samter, M., and Alexander, H. L.: *Immunological Diseases*, Little Brown & Company, pp. 794, 1965.
9. Kabat, E. A., Freedman, D. A., Murray, J. P., and Knaub, V.: A study of the crystalline albumin, gamma globulin and total protein in the cerebrospinal fluid of one hundred cases of multiple sclerosis and in other diseases, *Amer. J. Med. Sci.* 219:55-64 (Jan.) 1950.

The roles of the physician and the general hospital in management of alcoholism are again emphasized.

Plan for Treatment of Alcoholics in Hawaii: The Role of the Physician and the General Hospital

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• *Physicians can be of significant help to alcoholic patients through effective office management and general hospital care. Up to 80 per cent of alcoholics can be helped to control their drinking most of the time and to maintain or re-establish good family life, good work record and a respectable position in the community. The cooperation of physicians and hospitals will be needed to handle the increasing numbers of alcoholics that will be brought to hospitals as new laws come into use.*

ALCOHOLISM, as one of the nation's major health problems, deserves the serious concern of physicians and other members of the health professions.

General practitioners, internists, and other specialists have problem drinkers among their patients. The physician has an obligation to recognize alcoholism in his patient and to help the patient to accept his illness and to seek recovery.

Many definitions of alcoholism have been offered. The following definition is in the latest edition of the American Medical Association Manual on Alcoholism:¹

Alcoholism is an illness characterized by preoccupation with alcohol and loss of control over its consumption such as to lead usually to intoxication if drinking is begun; by chronicity; by progression; and by tendency toward relapse. It is typically associated with physical disability and impaired emotional, occupational, and/or social adjustments as a direct consequence of persistent and excessive use.

OFFICE MANAGEMENT

The drinking of alcohol has some positive value for the alcoholic, usually in relieving tension, anxiety, or guilt. Alcoholics resist giving up al-

cohol and avoid facing their alcoholism by using the defense mechanisms of denial, rationalization, regression, and projection of the blame onto the persons closest to them. When confronted with the threat of divorce, loss of employment, and loss of prestige, they may be forced to seek treatment. A physician can point out the signs of impairment of the health of his patient caused by drinking. He can encourage the patient to come to his own realization that his use of alcohol is out of control and must be stopped.

Treatment of the alcoholic begins by making the treatment situation and sobriety a rewarding experience for the alcoholic.² The physician should avoid a judgmental attitude and stress that drinking is a serious problem but not a moral one. The absence of a judgmental response by the physician is a rewarding experience for the patient. The prescribing of medication to relieve distress during withdrawal from alcohol establishes the physician in the patient's mind as a helping person who alleviates rather than inflicts pain. When sobriety is achieved, the physician can help the patient to experience a sense of accomplishment.

Dr. Marvin Block, Chairman of the Committee on Alcoholism of the American Medical Association from 1954 to 1964, has for years had a private practice of internal medicine in Buffalo, New York, devoted to the treatment of alcoholics. From his experience in the office management of alcoholics he offers this advice to physicians.³

The whole program of treating the abstaining alcoholic is a re-educational one. . . . In order to ascertain the type of individual with which we are dealing, we must look back into his history, not only his drinking history but also his personal history—his childhood, his environment, and his family. It is in this information that we may find some basis for the individual's use of a drug to make himself more comfortable, to meet problems and to overcome his feelings of inadequacy. When one has an intelligent patient who understands the importance of his background in relation to his present condition, explanation and discussion will often help him to understand

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himself. . . . In educating the abstaining alcoholic to continue his life and meet his problems without alcohol, we must go over the various problems that might confront him. . . . In ordinary problems of living, we must teach the patient to observe those around him who have the same problems but use other methods of meeting them. Emphasis must be laid on the importance of not necessarily solving every problem perfectly. The ability to accept partial solutions, the ability to compromise and adjust must be learned by repetitious discussion. This takes time and understanding on the part of the therapist, but proves extremely valuable to the patient. . . .

When the individual is advised in advance that treatment will continue for many months or even years, he does not expect too much from each visit. The change from visit to visit will be minimal, but good results can be seen from looking back over long periods of time. The patient should be told that one cannot undo years of training in a short time, nor can training for the future take place in a short time. . . . No matter how well motivated and conscientious the abstaining alcoholic is, there can and does come a time when he will drink alcohol. . . . The attitude of the physician becomes extremely important. The physician does not sit in judgment on his patient. It is important that he go over very carefully with the patient the circumstances that resulted in the slip; sometimes this experience can prove to be one of the most effective therapeutic factors.

AIDS IN OFFICE TREATMENT

Other aids in treatment are referral to Alcoholics Anonymous, a mental health center, other clinic or individual counselor, or to a clergyman for prolonged counseling and readjustment of patterns of living.

The physician can assist the patient in making the first contact with Alcoholics Anonymous. For those who accept the AA program, it provides hope that sobriety can be achieved and maintained; it provides the example of others who have achieved sobriety; it reduces anxiety and guilt by sharing of problems and helping others; and it provides confrontation in a peer group of the typical use of denial, rationalization, and projection. According to the *AMA News* of October 7, 1968, a survey of 11,355 alcoholics showed that 41 per cent stopped drinking upon joining AA, and another 23 per cent quit within a year.

The physician can help some alcoholic patients by the administration of disulfiram (Antabuse). This is a medication given orally which interferes with the metabolism of alcohol so that even one drink will cause a toxic reaction of a shock-like nature.⁴ The effect lasts four days or more. The alcoholic is instructed in the consequences of drinking while taking Antabuse. The knowledge that an unpleasant experience will result reinforces the alcoholic's resolution to abstain from drinking any alcohol. The dose of disulfiram is one pill (0.5 gm) daily for five days, then one-half pill (0.25 gm) daily for an indefinite period. This reinforcement may be needed for a couple of years.

Medical care of the intoxicated person may require hospital admission. Hospitalization is indicated to interrupt uncontrollable drinking, to combat the effects of the withdrawal state, to treat related physical problems, and to prepare the patient for definitive treatment on an outpatient basis.

The American Medical Association in 1956⁵ stated on recommendation of its Council on Mental Health that alcoholism comes within the scope of medical practice, that acute alcoholic intoxication often is a medical emergency, and that admission of an alcoholic patient to a general hospital should be judged on his individual merits, rather than be denied as a matter of general policy. It also pointed out the need for exposure of interns and residents to treatment of alcoholics as part of their medical training.

The American Hospital Association in 1957⁵ urged general hospitals to develop a program for the care of alcoholics and to base the decision as to admission of alcoholics on the condition and needs of the individual patient. "This progressive step would keep pace with increased recognition of (1) the general hospital as the community health center, and (2) alcoholism as a medical problem requiring a broad-scale attack if it is to be solved."

EXPERIENCE OF HOSPITALS

Various hospitals have reported good results from handling alcoholics in medical wards. Dr. Jack Gordon reported the experience of San Francisco's Mount Zion Hospital with unrestricted admission of alcoholics. Alcoholics did not disturb other patients, hospital routines were not upset, and most of the alcoholics were willing to undertake follow-up therapy. "The advent of the tranquilizing drugs has made sedation safer, simpler, and more effective, and has greatly facilitated the nursing and medical care of the detoxification and withdrawal period. In addition, our increased understanding of the psychological aspects of illness has prompted us to treat alcoholics in a routine, nonpunitive atmosphere with understanding and without discrimination. The alcoholic has responded both to drugs and to the atmosphere, and has become manageable."⁶

The Massachusetts General Hospital reported that follow-through on treatment recommendations was greatly improved if alcoholics were treated, while in the emergency ward, with understanding, sympathy, and attention to expressed needs.⁷

A survey⁸ of 79 Blue Cross Plans operating in 47 states disclosed that 49 (62%) of the plans provide benefits for hospitalization for alcoholism.

Various limits are placed on days of hospital care covered. Commercial insurance companies ordinarily cover hospitalization for alcoholism under group contracts. Most group and some individual and family major medical policies written by commercial insurers provide benefits for alcoholism both in and out of the hospital.

INTOXICATION SYNDROMES

Physical problems to be dealt with during hospitalization are related to alcohol intoxication or withdrawal syndromes.¹ Withdrawal syndromes may appear while drinking continues if the blood level is falling, after sustained heavy intake.

Coma—Mild to moderate alcohol intoxication ordinarily requires nothing but time for recovery, and no specific treatment is indicated. Alcohol coma is a medical emergency because death may ensue from respiratory depression. The following treatment is considered essential:

- Determine as rapidly as possible that there are no other causes for the coma (head injury, other drug intoxication, diabetes, infection, etc.) through prompt and complete physical examination and laboratory studies being carried out as treatment measures are instituted.

Valuable historical data may be obtained from family members or others accompanying the patient. Such persons accordingly should remain immediately available until after the cause of the coma has been established.

X-ray studies of the head and chest and examination of the blood for alcohol, barbiturate, and bromide levels should be made routinely. Careful lumbar puncture is indicated in the absence of signs of obviously increased intracranial pressure.

- If narcosis is profound, it is imperative that the airway be kept clear, using an endotracheal tube, if necessary. Place the patient on his side to avoid aspiration, after ascertaining there is no immediately apparent injury to the head, neck, or back.

- Supportive measures to correct shock, such as the administration of whole blood, intravenous fluids, and mechanical aids to breathing, should be initiated as needed. Oxygen or oxygen/carbon dioxide mixtures can be used when these appear indicated.

- Depending upon circumstances, gastric lavage may seem warranted, particularly if ingestion of other drugs is suspected. However, the danger of aspiration must be considered and guarded against, if the procedure is attempted.

- The urinary bladder should be emptied by catheterization, and drainage then initiated, with fluid intake and output observed carefully.

- Appropriate nursing care, such as checking vital signs frequently, suctioning, and turning the patient to avoid accumulation of secretions, is essential.¹

Withdrawal Syndromes—Withdrawal syndromes include tremulousness, hallucinosis, convulsive seizures, and delirium tremens. Symptoms of withdrawal are insomnia, anorexia, craving for alcohol or a sedative, mild depression, considerable anxiety, muscular weakness, and misinterpretation of visual and auditory stimuli. The characteristic tremor is made worse by activity or stress. Mild sedation and adequate oral hydration are needed.

Grand mal seizures may occur and may herald development of delirium tremens. The usual management of seizures is needed. Diphenylhydantoin and phenobarbital may be given intramuscularly.

In alcoholic hallucinosis, auditory or visual hallucinations are experienced. The patient may retain awareness that these are not real. Orientation, comprehension, and memory usually are not seriously impaired. Hallucinosis may be associated with restlessness, agitation, fitful sleep, nightmares, tachycardia, reduced muscular coordination, illusions, and some mental clouding. Treatment is mild sedation, oral fluids, and proper nutrition.

Delirium tremens is characterized by auditory, visual, and tactile hallucinations; confusion and disorientation; severe agitation and restlessness, insomnia; fever; profuse perspiration; and tachycardia. In about ten to fifteen per cent of the cases, death results from peripheral vascular collapse, hyperthermia, or an associated injury or infection. Continuous nursing care is needed in a quiet atmosphere. Maintenance of fluid and electrolyte balance usually requires intravenous administration of fluids.

Administration of paraldehyde is a traditional treatment for alcohol withdrawal syndromes. The method in use at Kings County Psychiatric Center is as follows:⁹

First 24 hours	10 ml paraldehyde every 4 hours if under 45; every 6 hours if over.
Second 24 hours	10 ml every six hours
Third 24 hours	10 ml at bedtime
Fourth 24 hours	10 ml at bedtime

In the absence of complications, the patient will be much improved in 24 hours. If fever persists or develops or if hallucinations persist or develop after 24 hours on this regimen, it is likely that a complication is present such as pneumonia, head injury, fracture, hepatitis, pancreatitis, or active syphilis.

SERVICES FOR ALCOHOLICS

REFERRALS

PHYSICIANS, POLICE, SOCIAL AGENCIES, FAMILIES
(THROUGH HOUSE STAFF OR ATTENDING PHYSICIANS)



EMERGENCY, ACUTE, AND INTERMEDIATE CARE AND TREATMENT

THE QUEEN'S MEDICAL CENTER
ST. FRANCIS HOSPITAL
LEEWARD OAHU HOSPITAL
HILO HOSPITAL
KONA HOSPITAL
MAUI MEMORIAL HOSPITAL
MOLOKAI GENERAL HOSPITAL
KAUAI VETERANS MEMORIAL HOSPITAL
WILCOX MEMORIAL HOSPITAL
SAMUEL MAHELONA MEMORIAL HOSPITAL



INTERMEDIATE AND LONG-TERM CARE AND TREATMENT

HAWAII STATE HOSPITAL
PRIVATE PHYSICIANS
DEPARTMENT OF SOCIAL SERVICES
PUBLIC WELFARE DIVISION
VOCATIONAL REHABILITATION DIVISION
MENTAL HEALTH CENTERS
FAMILY AGENCIES
ALCOHOLICS ANONYMOUS
HAWAII COMMITTEE ON ALCOHOLISM
OWN HOME
RELATIVE OR FRIEND'S HOME
NURSING HOME
FAMILY CARE OR BOARDING HOME
BOARDING HOUSE
SALVATION ARMY'S MEN'S SOCIAL SERVICE CENTER
HALFWAY HOUSE

authorize the police to take people found drunk in public to facilities designated by the Director of Health. The places designated will be hospitals licensed as psychiatric facilities. Enough hospitals have been named so that the load will be distributed and the police will not have to travel long distances. The cost of care of patients who are medically indigent will be paid by the Department of Social Services.

The shift in public drunkenness offenders from police hold and jail sentences to hospital care will increase the need for treatment and rehabilitation services after the short period of diagnostic evaluation and treatment in a general hospital. Facilities now available are the Halfway House, Salvation Army Men's Social Service Center, nursing homes, care homes, Hawaii State Hospital, and The Queen's Medical Center psychiatric unit.

RESULTS OF TREATMENT

There is little documented information about long-range results of treatment of alcoholic patients by general physicians, using general hospital and office treatment. According to the National Institute of Mental Health report *Alcohol & Alcoholism*¹² "Only a small percentage—perhaps less than 20% of all treated patients—have been able to maintain absolute abstinence for more than three to five years. . . . Recently, some leading therapists have been using a different basis of measurement in which success is considered achieved when the patient maintains or re-establishes a good family life, a good work record and a respectable position in the community, and is able to control his drinking most of the time. . . . (By this standard) a successful outcome can be expected in at least 60%, and some therapists have reported success in 70 or 80%."

REFERENCES

1. "Manual on Alcoholism" of the American Medical Association, 1967.
2. Kepner, E.: Application of learning theory to the etiology and treatment of alcoholism, *Quart. J. Stud. Alcohol* 25:279-291 (June) 1964.
3. Block, M.: Treating the abstaining alcoholic, *Medical Times* (Apr.) 1962.
4. Fox, R.: A multidisciplinary approach to the treatment of alcoholism, *Amer. J. Psychiat.* 123:769-778 (Jan.) 1967.
5. Block, M.: Criteria to be recognized as proper indications for hospitalization of alcoholic patients in guidelines for admission of alcoholics to hospitals. Smithers Foundation, New York City.
6. Barke, M., Gordon, J., Levy, R., and Perrow, C.: A study on the nonsegregated hospitalization of alcoholic patients in a general hospital, *Hospital Monograph Series No. 7*, American Hospital Assn., Chicago (Jan.) 1959.
7. Chafetz, M.: Establishing treatment relations with alcoholics, *J. Nerv. Ment. Dis.* 134:395 (June) 1962.
8. Christopher Smithers Foundation. "Guide Lines for Admission of Alcoholics to Hospitals." 1967.
9. Kissin, B., and Gross, M.: Drug therapy in alcoholism, *Amer. J. Psych.* 125:31-41 (July) 1968.
10. Rothfield, B.: Drug treatment of the acute alcohol withdrawal state, 12th Annual Conference, VA Cooperative Studies in Psychiatry, Denver, Colorado, April 1, 1967.
11. Tamura, R.: Personal communication, 1968.
12. Alcohol and Alcoholism, National Institute of Mental Health, Public Health Service Publication No. 1640, 1967. ■

RECENT CHANGES

Paraldehyde cannot be used for patients who have been taking disulfiram (Antabuse). Paraldehyde acts like alcohol in causing a toxic reaction in persons taking disulfiram.

Other studies have shown the value of chlordi-azepoxide (Librium) in management of alcohol withdrawal states.¹⁰ Dr. Raymond Tamura, Chief of the Mental Health Division's Alcoholism Clinic, uses 100 mg Librium intramuscularly on admission of the agitated patient, repeated in two to four hours if necessary, and followed by 25 mg four times daily by mouth.

Act 6 of the 1968 session of the Hawaii State Legislature repeals the statute designating public drunkenness as a crime, effective January 1, 1969. It amends the new mental health law of 1967 to

*ABO typing is easier if you use blood—but
it can be done just as accurately with one hair!*

ABO Blood Groups in Human Hair

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● *ABO blood groups can be determined by agglutination of red blood cells using specific antisera such as anti-A and anti-B. Leucocytes, platelets, and other blood corpuscles can also be identified by agglutination and other serologic methods. Since a trace amount of blood group substances has been found in serum, it is believed that other body fluids such as saliva, tears, sweat, and urine can also demonstrate these substances. Furthermore, skin and organ tissues are known to have blood group substances.*

THE PRESENT study considered the possibility of determining blood group substances in human hair^{1, 2}. Two different methods, using direct and indirect determinations, indicated the presence of ABO blood group substances in hair. The present procedure can be applied to medico-legal investigations for personal identification.

MATERIALS AND PROCEDURES

Antisera reacting specifically with A or B cells respectively were prepared by screening human sera obtained from Kuakini Hospital. A preliminary study was carried out using commercially available anti-A and anti-B grouping sera. The final tests were conducted using selected sera which contained potent anti-A or anti-B qualities.

Serum containing single anti-A activity was obtained from blood group B individuals, anti-B serum from group A individuals, and anti-A+B from group O individuals; these were used as reactors.

Red blood cells possessing A and B groups respectively were used in mixed agglutination tests as indicator cells.

PRETREATMENT OF THE HAIR

Hair samples were obtained from individuals of a known blood group (A, B, AB, or O). One strand of hair, at least 8 cm long, was found to be sufficient.

Each sample was washed by stirring it with a magnetic mixer in a 100-ml beaker containing soapy water. After the washings, the hair was rinsed in distilled water using the same procedures. After rinsing thoroughly, the samples were dried on paper towels.

Squibb ether was poured on the hair samples, which were separated in test tubes labeled A, B, AB, or O. The specimens were soaked for one hour to permit thorough degreasing.

Using a pipette, the ether was removed from the hair, which was then dried in a dry incubator for approximately thirty minutes at 109°C. After 30 minutes, the hair was placed between sheets of thin paper (e.g. glassine) and flattened by repeated crushing with a hammer.

The hair was pounded on a wooden block, concrete, and a metal anvil, but grinding with a mortar and pestle produced the best results. This step is of great importance: in order to insure successful completion of the experiment, the hair must be crushed until it is splintered into minute fragments. The hair particles were then placed into test tubes in equal amounts.

SENSITIZATION

Three drops of antiserum were added to the

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FIG. 1.—Photographic illustrations of mixed red cell agglutination patterns with hair.

hair (Figure 1 and Table 1). The hair and anti-serum mixture was incubated at room temperature for two hours to provide adequate reaction time between the two.

WASHING

Caution must be used in washing. The test tube containing the hair samples and excess antiserum were filled with saline. The sets of test tubes were centrifuged at 2,000 rpm for five minutes. After centrifugation, the saline was carefully removed with a pipette until only the sensitized hair remained. This process was repeated three or four times to remove all excess serum proteins and to prevent false readings.

ELUTION

Three drops of saline were added to the washed hair, which was then incubated in a water bath at 55° for ten minutes. The antiserum which had been previously fixed on the hair by sensitization was now freed by the high temperature. The eluates were tested against the indicator cells to demonstrate the presence of isoagglutinin activity. However, the direct method demonstrated the blood cells affixed to the hair, showing clear cut results. Therefore, the elution technique was omitted in later studies.

READING

One drop of test group A or B red blood cells (two per cent suspension in saline) was added to the mixture and left standing at room temperature for five minutes to allow the cells and sensitized hair to combine. The tubes were then centrifuged for two minutes at 2,000 rpm.

TABLE 1.—Reaction patterns of indicator cells for determination of ABO blood group in hair.

HAIR	ANTISERUM	INDICATOR CELLS	REACTION READING
A	Anti-A	A	+
	Anti-A	B	—
	Anti-B	A	—
	Anti-B	B	—
B	Anti-A	A	—
	Anti-A	B	—
	Anti-B	A	—
	Anti-B	B	+
O	Anti-A	A	—
	Anti-B	B	—
AB	Anti-A	A	+
	Anti-A	B	—
	Anti-B	A	—
	Anti-B	B	+

Next, the hair samples were poured onto a microscope slide and observed under 10× magnification. The agglutinations, if any, remained on the hair and the readings were accurate. When using the elution technique the tubes were read over a concave mirror. This method of reading was sometimes unreliable because agitation of the tubes after centrifugation dispersed the weak agglutinates and produced false readings.

RESULTS

As shown in Figure 1, indicator cells A or B agglutinated on hair possessing A or B blood group substances respectively, and exposed to anti-A or anti-B respectively.

Positive agglutination was seen when hair, anti-serum, and indicator cells were corresponding, negative when the systems were incompatible. The identification patterns of the blood groups are shown in Table 1. In general, positive reactions were produced by the agglutination of five or more red-blood-cell masses located at the ends of the hair. Agglutination was also seen along the sides of the hair, but barely visible when located on the hair, due to the dark background. Positive mixed agglutination was seen in high incidence when smaller smashed pieces of hair were used. When the elution technique was applied, agglutinates were seen in the field under microscopic examination.

DISCUSSION

Hemagglutinin tests using the mixed agglutination technique demonstrated that human hairs contain specific blood group substances depending on their blood groups. The following steps should be carried out carefully:

(1) Complete degreasing of hair by washing with soapy water and ether.

(2) Crushing the hair with a hammer or grinding it with mortar and pestle to obtain the greatest possible exposure of the inner material which contains the blood group substance.

(3) Placing the material, hair + antibody + red blood cells, onto the microscope slides from the test tubes when the agglutination occurs.

(4) Elimination of the excess serum proteins after sensitization.

The present study showed that specific reactions occur between hair containing specific blood group substances, specific antibody, and red blood cells containing a specific blood group. For example, the hair from a group A individual reacted with its corresponding antibody, anti-A. In turn, this complex reacted with group A red blood cells when the latter were used as indicator cells. These complexes can be clearly observed under microscopic examination. Hair from group O individuals did not show such mixed agglutination when using either anti-A or anti-B sera, or by adding A or B indicator cells.

As shown in Table 1, hair blood groupings were identified by agglutination patterns of red blood cells after exposure to their corresponding antiserum. In this study, the blood group substances

were determined by direct agglutination and by indirect agglutination using the elution technique.

The antibodies previously exposed to the hair were dispersed from the complex and their reactions with red blood cells depended upon the antigens and antibody systems. The eluates possessed specificity to the reactions with red blood cells corresponding to the antiserum. The blood groups of hair determined by the direct and indirect methods were similar to standard blood grouping techniques using red blood cells and sera.

It is hoped that this method can be applied to medicolegal investigations regarding personal identification in murder and disputed paternity cases.

It is assumed that this method can be used to detect blood groups of hair which have been either stored or exposed for many years, since the blood group substances are stable against heat. Therefore, the identification of the blood groups of hair will also provide information for anthropological studies.

REFERENCES

1. Yada, S., Okane, M., and Sano, Y.: Blood grouping of a single human hair by means of elution technique. Blood grouping of aged and formalin fixed human hairs, *Acta Crim. Japan* 32: 7-8 (July) 1966.
2. Yada, S., Mori, M., and Okane, M.: The occurrence of the A and B blood group antigens in the hair of the various species of animals, *Acta Crim. Japan* 32:15-17 (July) 1966. ■

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NEW YORK, JULY 13-17

The Rubella Problem in Hawaii

The past decade has witnessed a revolution in our understanding of and ability to deal effectively with rubella. The crucial discovery of rubella virus in 1962 made available, for the first time, specific means for diagnosing the disease and relating defects in the child to maternal infection during pregnancy.

The 1964-65 nationwide pandemic provided, tragically, extensive documentation of the devastation that a single virus infection could wreak on the growing human fetus. To the well-known defects of congenital deafness, cataracts, glaucoma, heart defects, microcephaly, and mental retardation has been added the following partial list: "failure to thrive" syndrome, thrombocytopenic purpura, hemolytic anemia, hepatitis, hepatosplenomegaly, lesions of the bones, encephalitis, and abnormal fingerprints. It has been estimated that, at a minimum, 30,000 children with one or more of these defects were born in the United States as a result of the 1964-65 epidemic and that the burden of rehabilitation of these individuals over the next 20 years will be 28 billion dollars.¹

Against this background, it is disturbing to learn from unpublished studies of Halstead and co-workers at the University of Hawaii School of Medicine² that as many as seven in ten women of child-bearing age born in Hawaii are still susceptible to rubella. This compares with less than one in ten on most of the mainland. The registry at the Birth Defects Center and the sharply increased enrollment of partially deaf children in Honolulu pre-school classes this year, are evidence that this high susceptibility rate has left its toll of abnormal children. It is disturbing to note that as this is written, seasonal rates for rubella are higher than in any year since 1965.

Fortunately, help is at hand. A specific and highly effective vaccine has been developed and

should soon be released for general use. It should *not* be used in women except under extraordinary circumstances; our USPHS believes it should be used to prevent rubella in children—the major source of infection. The following comments paraphrased from the Public Health Service Advisory Committee on Immunization Practices³ deserve careful consideration:

"Since rubella vaccine is a live virus, it is not known to what extent infection of the fetus with attenuated virus might take place or whether damage to the fetus could result. Women of child-bearing age may be considered for vaccination only when the possibility of pregnancy in the following two months is essentially nil. This approach is indicated for two reasons: first, because of the theoretical risk of vaccination in pregnancy; and second, because significant congenital anomalies occur regularly in approximately three per cent of all births, and their fortuitous appearance after vaccine had been given during pregnancy could lead to serious misinterpretation."

It is important also to note that the HPV-77 vaccine strain can be expected to produce one or more of the following in over 50 per cent of adult women: fever, lymphadenopathy, rash, and polyarthralgia or arthritis.⁴

For reasons stated above, the Communicable Disease Committee of the HMA has recommended that an intensive campaign be undertaken to protect women by interrupting transmission of rubella in Hawaii by immunizing those who are the major source of disease spread, children ages one through twelve. It is advised that vaccination of women, if undertaken, should be done in persons known to be without rubella antibody, who are not pregnant, and who consent to avoid pregnancy for two months following vaccination.

The epidemic of 1964-65 revealed that many

women, particularly in low-income groups, did not know of the causal relationship between rubella and congenital malformations in their offspring.⁵ Many will confuse rubeola and rubella

and claim immunity or prior immunization for their children. The solution of the rubella problem in Hawaii will require a major effort in health education on the part of physicians.

SCOTT B. HALSTEAD, M.D.

REFERENCES

1. Cooper, L. Z., Ziring, P. R., Ockerse, A. B., Brody, M. R., Krugman, S.: Congenital rubella: clinical manifestations and management. *Amer. J. Dis. Children.* (July) 1969 (in press).
2. Halstead, S. B., Diwan, A. R., and Oda, A. I.: Susceptibility to rubella in adults in Hawaii. *HAWAII MED. J.* (to be published).
3. Recommendation of the Public Health Service Advisory Committee on Immunization Practices. Morbidity and Mortality Weekly Report, Vol. 18, No. 15, Week ending April 12, 1969.
4. Weibel, R. E., Stokes, J., Jr., Buynak, E. B., Hillerman, M. R.: Rubella Vaccination in adult females. *New Eng. J. Med.* 280:682-685, 1969.
5. Pineda, R. G., et al.: Impact of 1964 rubella epidemic on a clinic population. *Amer. J. Obst. & Gynec.* 100:1139-1146, 1968.

The Biology of Overcrowding

Toynbee has recently suggested that we are now actually engaged in World War III. The reason we haven't realized it is that it is being waged, unlike previous wars, not by nation against nation, but by college students and other individuals against the impersonal, computerized Establishment.

One major factor in it may well be—if we can take a lesson from biologic studies of the behavior of rats—the human response to overcrowding. Consider the following observations of the behavior of the members of a rat colony in which overcrowding is permitted to occur:¹

“... Calhoun found that as the density of the population increased, the organization of the culture gradually became unhinged, and individuals began to display the most extraordinary types of pathologic behavior. . . . Some became timid, withdrawn, and then somnambulistic. Others began to fight incessantly in efforts to dominate the group. The females gave up the scrupulously tidy house-

keeping which is the normal mark, and they made careless, inadequate nests, or no nests at all, with the result that neonatal mortality became very high. Then, as population density increased still further in this confined space, the ‘probers’ appeared. These were small groups of three or four males which roamed the pen together and engaged in homosexual activities or in the mass rape of females, and in cannibalism. The most remarkable and disturbing characteristic of the probers was their hyperactivity. They kept in constant movement, hostile to all other rats in the colony and inexhaustible in their efforts to make trouble.”

It seems quite possible that we are beginning to pay the penalty for flouting Nature's population-limiting hazards; traffic deaths, and war casualties, are not an adequate substitute for deaths from disease. The population explosion is not a hazard of the future: it is here; it has created overcrowding; and perhaps humans have the capacity to react pathologically to overcrowding, just like our cousins, the rats.

1. Calhoun, J. B.: Population Density and Social Pathology, *Scientific American* 206:139 (Feb.) 1962.

The Brilliant Thoughts of Chairman Mao

A surgical case report in a current (August, 1968) issue of *China's Medicine* illuminates the communist medical mind in China and shows clearly that atheism is not incompatible with a devoutly religious attitude.

The patient had a retroperitoneal neurofibroma (later found to weigh 45 kilograms!) and had been refused surgery in other hospitals. At *this* hospital, the report says, “We said with one voice: ‘The counter-revolutionary revisionist line pushed by China's Khrushchov in medical work regarded her disease as “incurable” but we must cure her by every possible means under the guidance of Chairman Mao's revolutionary line. . . .’”

“The first order we wrote on her case record was ‘Propagate Mao Tse-tung's thought so as to build up the patient's confidence in combatting the disease.’ . . . the health worker read to her Chairman Mao's works sentence by sentence . . . the brilliant thought of Chairman Mao . . . made her understand that she was the victim of the counter-revolutionary revisionist line in medical and health work pushed by China's Khrushchov and deepened her hatred for him. . . . She asked the health worker to hang a portrait of Chairman Mao where she could see it. . . . She often said with deep emotion, ‘Chairman Mao, Chairman Mao! With your brilliant leadership, I shall be saved.’”

Then to the operation. "With its four walls decorated with Chairman Mao's portraits and quotations, the operating room looked even brighter and solemn." "

"The operation was performed by five comrades. . . . If a problem should arise during the operation, the political guidance group would have those present discuss it and make a decision by general agreement." Within five minutes, hyperpnea and cyanosis and tachycardia were noted; "at this crucial moment, the leaders of our Army unit loudly read to us Chairman Mao's teaching: 'What we need is an enthusiastic but calm state of mind and intense but orderly work.' The political guidance group immediately asked us to look for the cause. It was found . . . and the problem was solved."

Presently the tumor was exposed. "At this point, the political guidance group read us Chairman Mao's teaching promptly: 'Our duty is to hold ourselves responsible to the people. Every word, every act and every policy must conform to the people's interests.' This made a strict demand on us. In the light of this instruction we decided to lengthen the incision to 95 cm. . . ."

In a commentary which follows this remarkable case report, the anonymous author of the report has some hard words for the "Soviet revisionist renegade clique" which criticized them (in *TASS*) for depending on the thoughts of Mao Tse-tung for guidance in a surgical operation. The critique ends with this remarkable paragraph:

"Although in our operation we have only removed a tumor of the human body, we fully realize that imperialism, modern revisionism and the reactionaries of all countries are a huge tumor of present-day society. However terrible its appearance may be, the people all over the world are resolved to remove this tumor. We are convinced that the revolutionary people armed with Mao Tse-tung's thought not only can remove huge tumors of the human body but can also remove from the globe, with their revolutionary scalpels, imperialism, revisionism and all reactionaries—this huge tumor which endangers the lives of the people of the world—wholly, thoroughly and completely."

And we are naive enough to suppose that it is possible to negotiate across a bargaining table with people like this!

The Regional Pediatric Pulmonary Program

The Kauaikeolani Children's Hospital was awarded \$210,852 by the Hawaii Regional Medical Program for a pediatric pulmonary program with a pulmonary center, to be established at the Children's Hospital. Coincident with this federal allocation, the Lani Booth Trust gave the hospital \$150,000 for its Center, raising the working capital to over \$360,000. The trustees of the Children's Hospital have therefore named it the Lani Booth Pediatric Pulmonary Center.

The primary goal of the program is to recognize, and provide better care for, respiratory problems of children throughout the state, and not to cause major shifts in patient load. There are at present five participating hospitals (Children's, Queen's, Kapiolani, Kaiser, and Hilo), with the prospect of additional participants as the program develops. Severe asthma and allergy, respiratory distress or failure of infants, and congenital pulmonary problems are some target diseases. Continuing education of nurses and physicians is also of vital concern. Visiting authorities as well as the core staff will lecture and conduct symposia on pulmonary problems. On-the-job teaching for

nurses will be practiced by the Center. It is envisioned that participating hospitals will rotate their nurses through the Center for short periods of training.

Participating hospitals will receive incubators, monitoring and other equipment to improve their delivery of care. More complicated cases such as those requiring assisted ventilation or elaborate diagnostic studies will be transferred to the Center at the request of the patient's private physician. While in the Center the patient will remain under the jurisdiction of his own physician with the support of the core staff.

Since patient care, teaching, and clinical research are inseparable in good medicine, the Pulmonary Program will afford an opportunity to practice exemplary care. Much interest is being generated, and we hope ever increasing support of the medical community will continue. We are both gratified by the opportunities afforded us, and sobered by the task of achieving these goals.

WALTON T. K. SHIM, M.D.

SHARON J. BINTLIFF, M.D. ■



Hawaii Academy of General Practice

... at long last, the doctor's role in economics is being recognized!

January 23, 1969, is a date that can be entered in the annals of the history of medicine in Hawaii as a milestone of progress.

On that day, at the Mabel Smyth Building in Honolulu, venerable home of the Hawaii Medical Association, a short man-about-town by the name of Arthur Rutledge, whose reputation as an infighter is so well established in the intertwining circles of Union and Management that he can afford to be soft-spoken and humorously familiar with commoner or king—Art Rutledge himself came forth with the proposition that maybe, just maybe, both Union and Management should ask the doctors to participate, yes, actually participate in negotiations involving their services when “package deals” and medical benefits are up for renegotiation. Will wonders never cease!

The occasion was a joint meeting of the HMA's Bureau of Research and Planning (Ted Tomita founded it as The Long Range Planning Committee) and the Public Relations Committee. Mr. Rutledge had invited himself to it by initiating a letter to HMA President Miyamoto, expressing concern over the rising costs of medical care.

Mr. Rutledge's hat-in-hand attitude, however, did not really conceal his primary purpose. Following closely upon the nationwide plea on behalf of Medicare by HEW's retiring Director Wilbur J. Cohen for physicians to keep the lid on escalation of medical fees, Mr. Rutledge seized the opportunity to try to interrupt the upward spiraling of all costs, by zeroing in on the doctors. He introduced the subject of discussion at this meeting by describing the historical panorama of the unions winning benefits from the employers, only to see the value of these benefits shrink as over-all costs went up. He is in hopes that whatever fringe benefits in the medical aspects of future contracts can be won, will not again disappear, and he aims to make certain this remains so, by cajoling us into guaranteeing fixed fee schedules and unchanging conversion factors over the period of the life of the contracts.

Physicians' fees, as well as hospital costs, are indices of the cost of living just as are wages, salaries, and corporation profits. Mr. Rutledge must surely grant organized medicine the right to request of him, as one representative of Labor, that *Labor* be the first to break the spiral of escalation. Labor, after all, is a far bigger segment of the GNP. Or, we physicians could just as rightfully ask that the price of steel be lowered first, as a step toward deescalation. Why should Medical Care be asked to bear the brunt of stepping out into the economic morass? Is it because we have been the last, and, therefore, the ones seemingly the most rapid in the upward spiraling of costs?

We think Mr. Rutledge sensed at this meeting that we were willing to meet him and his ideas more than halfway, despite the fact that we were aware of what he was driving for. The physicians of Hawaii have long been seriously concerned that our services have been bargained for without as much as a by-your-leave, as if it were always a foregone conclusion that we would provide the services no matter what low levels of charges were written into union-management contracts. In fact, that is also one of the reasons we have been displeased with HMSA, whose lay board has participated in these negotiations and offered package benefits without consulting organized medicine.

If Mr. Rutledge, and Mr. Bernie Stern (who was also present, representing the Employers Council at this milestone meeting), now feel that it is time we physicians were in on planning of the medical benefits up for grabs, we sincerely welcome this “new” approach. Those of us in the HMA who are genuinely concerned with the future of medical care in Hawaii will be only too happy to help guide that future.

We have become too well educated in the school of modern medical economics, however—thanks to HEW—to be easily taken for suckers anymore. Mr. Rutledge, and Management, might well be reminded, therefore, that we are offering to help, but not to go it alone. The medical profession has no intention of becoming the whipping boy of economics.

J. I. FREDERICK REPPUN, M.D. ■

Tuberculosis, Cancer, or Melioidosis?

Assuming the gradual cessation of hostilities in Vietnam over the next 12 months, many war veterans will be returning to civilian life. Some of these will undoubtedly present to their family physician with cavitary lung lesions exactly resembling tuberculosis. In many cases these lesions will be due to chronic infection with *Pseudomonas pseudomallei*, an organism prevalent in Southeast Asia which is pathogenic for man, producing the disease known as melioidosis. Failure to appreciate the true nature of the lesion can lead to futile and prolonged treatment for tuberculosis. When it fails to respond to anti-TB drugs the physician, fearing that he has been treating a cavitary type of bronchogenic carcinoma, has the "tumor" removed surgically. The sad end result of this series of therapeutic misadventures may be a chronic, discharging, bronchopleurocutaneous fistula.

The first essential in the management of melioidosis is an awareness that such a disease exists. Any Vietnam veteran with a cavitary lung lesion should be suspected of having the disease and appropriate diagnostic studies performed. As the greatest expertise in the diagnosis and treatment of melioidosis is found in military hospitals, the patient should probably be referred to one of these institutions. Currently the organism seems to respond to tetracycline, but modifications in therapeutic regimens are to be anticipated as more clinical experience accumulates.

Radiologists Richly Rewarded

A recent newspaper story highlighted the growing concern of local health authorities over the increasing incidence of tuberculosis among recent immigrants to the U.S., despite, in some cases, normal chest x-rays' being presented for inspection at the time of their arrival in Hawaii.

The experience of a Honolulu business man visiting the Far East a few months ago seems to illuminate this vexing problem somewhat. Following a succession of bacchanalian revels, an acute exacerbation of his gouty arthritis necessitated his admission to a Seoul hospital. After a few days of rest and recuperation, he was ready to resume his travels, but his discharge was delayed for a few days while at least ten repeat chest films had to

be taken before, he was told, a satisfactory one could be obtained. To his relief, it turned out to be quite normal.

A few days after his discharge he learned that his chest films were being sold for \$100 each to prospective U.S. immigrants, who were afraid of being rejected because of previous pulmonary tuberculosis!

Fatal Oriental Treat

This title does not refer to a liaison with Mata Hari, but to the possible carcinogenic properties of a favorite Far Eastern delicacy, soya paste. This paste is the residue of moldy wheat left after making soy sauce, and it contains powerful carcinogens known as aflatoxins. Researchers have not as yet determined whether soy sauce itself has any cancer-producing potential, but they are rumored to be casting a suspicious look at those little black bottles.

Virulent Vaccinia Virus

Thinking pediatricians find themselves impaled on the horns of a dilemma when considering the desirability of smallpox vaccination. At the present time, a child living in the United States is at greater risk of dying from a complication of smallpox vaccination if he is vaccinated, than of contracting smallpox if he isn't. The two most serious hazards which may occur very soon after vaccination are generalized vaccinia and encephalitis.

Now it appears that there may be a late-developing complication: malignant tumors occurring in the vaccination scar. California dermatologists report six cases of this: four basal cell carcinomas, a squamous cell carcinoma, and a melanoma. All of the four cases of basal cell carcinoma occurred in residents of Southern California, and prolonged sun exposure was thought to be a contributing factor.

A stroll along Waikiki beach quickly convinces one of the inherent difficulty in finding a vaccination site which will not be exposed to the sun at some time or other. Perhaps the inner surface of the upper arm—taking care to avoid any pigmented moles, of course—might be a suitably shady spot.

W. PHILIP JONES, M.D. ■

This is the seventy-eighth installment of In Memoriam—Doctors of Hawaii.

Gordon Hitt Lightner

Dr. Gordon Hitt Lightner, who for 25 years was head of the Medical Department of Hawaiian Commercial and Sugar Company, died August 10, 1954, at the Lightner farm in Bollingbrook, Upperville, Virginia. He was 62 years old.



DR. LIGHTNER

He was born September 4, 1891, at Greenville, Virginia, son of Milton H. and Caledonia Green Lightner.

He attended the University of Virginia and received his medical degree from there in 1918. After enter-

ing the Navy Medical Corps during World War I, he saw service in Hawaii, and decided to live in Hawaii when he was separated from the service.

Dr. Lightner was married to Amelia Benson Bain of Portsmouth, Virginia.

On July 15, 1921, he joined Hawaiian Commercial and Sugar Company, where he served continuously as head of the Medical Department for a quarter of a century. When he retired in 1950 he left for Virginia where he operated a large farm until his health failed.

Dr. Lightner took an active and social interest in Valley Isle affairs and was a prominent leader in the Maui and Territorial Medical associations, serving the former group as president in 1935-1936.

Frank Arents Plum

Frank Arents Plum was born in 1888. He was a graduate of the University of Washington, and the University of Pennsylvania Medical School granted him an M.D. in 1915. Dr. Plum served an internship at The Queen's Hospital in Honolulu and then went on to take specialty training at the Mayo Clinic, Rochester, Minnesota.

During World War I, Dr. Plum served on General Pershing's staff.

The Hawaiian Directory of 1922 lists him as practicing in Honolulu and specializing in diseases of the eye, ear, nose, and throat. Shortly thereafter he moved to Seattle. Returning to Honolulu in 1928, Dr. Plum was associated with Dr. James A. Morgan, and added brain surgery to his other specialties. In January, 1937, he left the Islands to set up practice in Tacoma, Washington.

Dr. Plum practiced in Tacoma until his death which occurred on November 16, 1957, at the age of 70.

He is survived by his wife, Kathryn, and a son, Albert.

During his years here, the doctor was a member of the Hawaii Medical Society. At the time of his death, he was a member of the Washington State Medical Association, the American Medical Association, and the Pacific Coast Oto-Ophthalmological Society.

Gensho Hasegawa

Gensho Hasegawa was born in 1876 in Chiba Prefecture near Tokyo, the son of Genetsu and Taki Seki Hasegawa. He and his brother, Dr. Chikami Hasegawa of Honolulu, were the fourth generation in the family to follow the medical profession. His early education was received in Chiba and he graduated from the Chiba Medical School and continued with post-graduate studies at that institution. Following this he entered the service of the local government at Chiba, later becoming head of a hospital.

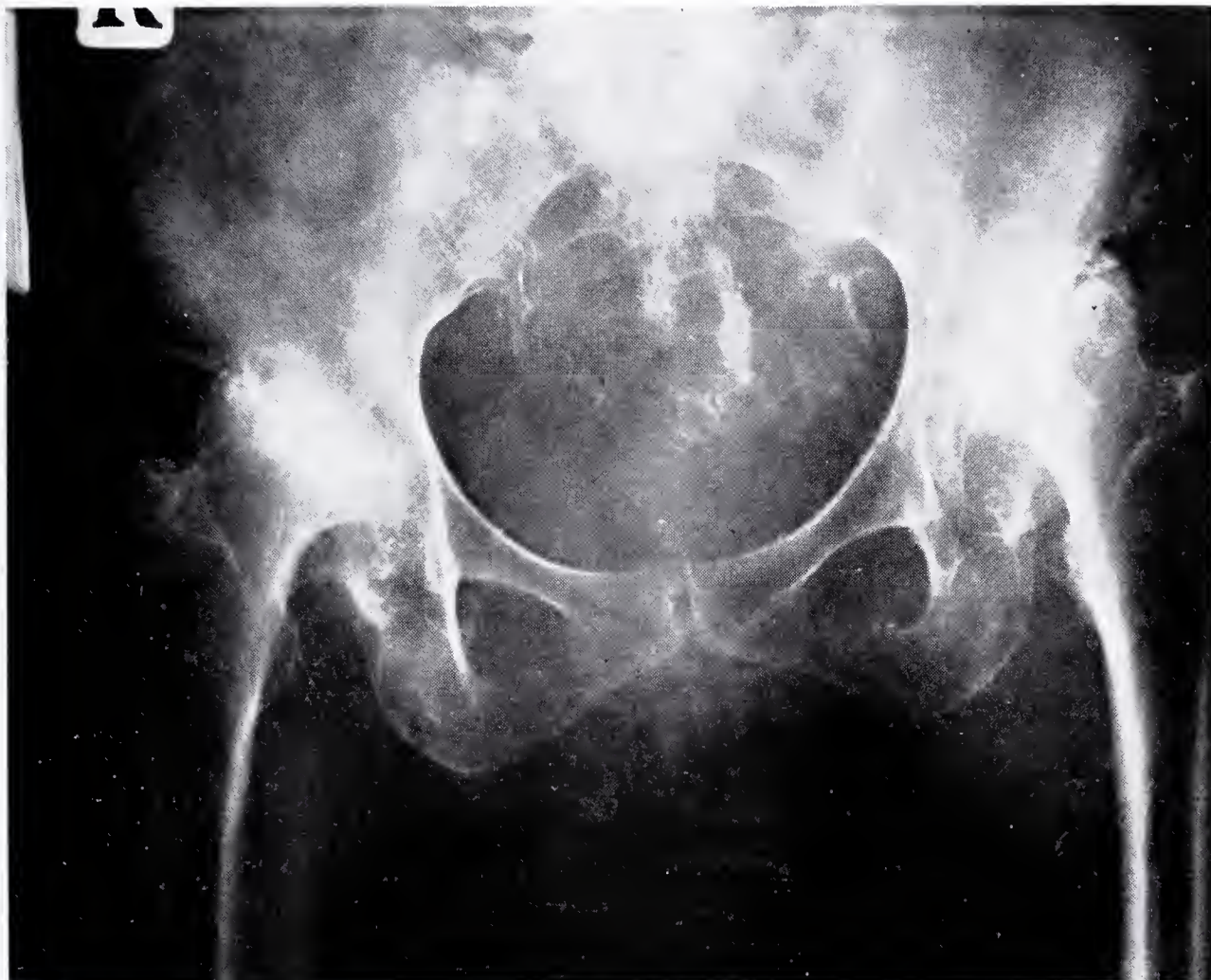


DR. HASEGAWA

In 1903 Dr. Hasegawa came to Hawaii, and was licensed to practice in the Territory in November of that year. He soon opened the Hasegawa Hospital in Honolulu, which he operated until 1907 when he moved to Waialua. In April, 1910, he went back to Japan for additional study.

Returning to Honolulu in February, 1911, Dr. Hasegawa was accompanied by his wife, Chieko (Iwase) whom he had married in Tokyo. On his return the doctor opened an office in Honolulu

continued page 417



- A 64-year-old Chinese woman with generalized osteoarthritis complained of weakness of the legs and "bad bone pain" in both thighs, and easy bruising for the past three years. There was no history of trauma. Both forearms showed spontaneous patchy purpura. She had had dermatitis herpetiformis since 1958 and was treated for stasis dermatitis with ulceration in 1965.
- Roentgenograms showed flattening and sclerosis of both femoral heads with loss of joint space and cephalad subluxation.
- What is your diagnosis?
- Answer is below.

X-ray diagnosis: idiopathic aseptic necrosis of both femoral heads with bilateral subluxation and

degenerative arthritis, probably due to hypercortisomism. Aseptic necrosis of the femoral heads may occur without apparent cause, but it is somewhat commoner in alcoholic men and in women with estrogen deficiency. Its incidence is also increased in hyperuricemia, Gaucher's disease, sickle cell anemia, congenital malformations and dysplasias of the hip joint, and hypercortisomism. This patient had been controlling her dermatitis herpetiformis with corticosteroids and had been able to take about 4 mg of triamcinolone daily for about ten years by going from doctor to doctor. No other causes were suggested by clinical or laboratory data.

Submitted by the
RADIOLOGICAL SOCIETY OF HAWAII
VIRGIL R. JOBE, JR., M.D. ■

★Surgery of Ptosis (Blepharoptosis)

By Sidney A. Fox, M.S. (Ophth.), M.D., F.A.C.S., 238 pp., \$15.75, Grune & Stratton, 1968.

THIS IS AN EXCELLENT source book on the surgical treatment of ptosis. The historical contributions to the various techniques of elevating the upper lid and the recent refinements and modifications are beautifully illustrated and described in detail. Anyone doing occasional ptosis surgery would do well to refresh his memory with this text. The anterior skin approach is favored by the author. The chapter on complications of levator surgery is well written and very complete, with a statement of precaution for each listed complication.

WAYNE W. WONG, M.D.

Strabismus in Childhood

By Herbert M. Katzin, M.D., and Geraldine Wilson, R.N., 84 pp., The C. V. Mosby Company, 1968.

THIS LITTLE BOOKLET, intended for parents of children with strabismus, is written from the standpoint of present-day accepted methods of treatment. The explanations are detailed and complete, and this may cause more problems with parents, who may try to "read into" the examples given their own child's problem. This booklet should be very helpful for nurses interested in ophthalmology. It should also be useful for pediatricians, who may properly guide the anxiety of their patients' parents in problems related to strabismus. It may be timesaving to an ophthalmologist to permit an anxious mother to learn more concerning her child's eyes.

WAYNE W. WONG, M.D.

★Surgical Pathology, 4th Ed.

By Lauren V. Ackerman, M.D., and Harvey R. Butcher, Jr., M.D., \$27.50, The C. V. Mosby Company, 1968.

AMONG MANY ADDITIONS and revisions in this new edition of *Surgical Pathology*, I was much impressed by those in the chapter of the skin tumors. The skin tumors, which comprise one of the common problems for the practicing pathologists, are only briefly described in most of the textbooks of pathology. This chapter in this edition will not only help the pathology residents understand the various forms of skin tumors, but also contains a table reference of great value for the practicing pathologist.

The chapter about nevi and melanoma is also well written. One of the most difficult problems in diagnosing these lesions is probably the differential diagnosis of melanoma and juvenile spindle-cell nevus. Some brief remarks concerning this problem would have been appreciated.

The neuropathology section is well written within its limited pages. However, more emphasis on brain tumors, with increased clinicopathologic correlation, and more photomicrographic illustrations would have been of value. Biopsy of CNS and PNS for diagnosis of the lipidosis and related conditions, including leukodystrophies, has become an important diagnostic procedure. Some brief description as to the practical aspects of these conditions should be included. Rectal biopsies for many of these diseases are also not mentioned.

I was pleased to note a change in the printing format. The pages are set in two columns of print, rather than a whole page, making quick reference to a subject somewhat easier.

HIDEO NAMIKI, M.D.

★ means highly recommended.

★Pediatrics, 14th Ed.

By Henry L. Barnett, M.D., with the collaboration of Arnold H. Einhorn, M.D., 1,847 pp., \$24.50, Appleton-Century-Crofts, 1968.

BARNETT'S *Pediatrics* is one of the oldest pediatric textbooks in existence, having first appeared as the *Diseases of Infancy and Childhood* in 1897. This 14th edition, however, is by far the newest and the best of all pediatric textbooks on the market. The book, completely revised, now encompasses the complete field of pediatrics. The list of associate editors and contributors includes the elite of the pediatric world. There are chapters on genetics, cytogenetics, immunology, vectorcardiograms, pediatric neurology, and even school problems. In most cases, the basic physiology and biochemistry are also covered in a simple manner.

The only fault I found was that the bibliographies at the end of each chapter include very few journal articles. They mostly refer to other textbooks.

I was so impressed with this book that I ordered one for myself as my basic textbook on pediatrics. I am sure other physicians will follow suit once they have reviewed this most excellent book.

SORRELL H. WAXMAN, M.D.

Also Received

Clinical Interpretation of the Wechsler Intelligence Scale for Children (WISC)

By Alan J. Glasser, Ph.D., and Irla Lee Zimmerman, Ph.D., 152 pp., \$5.75, Grune & Stratton, 1967.

THIS PAPERBACK edition is recommended for those interested in the practical application of the WISC, i.e., the administration and scoring, the reporting, the subtest analysis and the projective aspects of this test.

Infection Control in the Hospital

By American Hospital Association, 140 pp., \$3.75, American Hospital Association, 1968.

THIS PAPERBACK should be of value for the Hospital Infection Committee.

Inservice Education

By Russell C. Swansburg, R.N., M.A., Major, USAF, NC., 339 pp., \$7.00, G. P. Putnam's Sons, 1968.

THE SELF-INSTRUCTION text is written for the directors of inservice education and should aid the nurses in their quest of the best method of continuing education.

Comprehensive Review for Medical Technologists

Edited by Francis E. Dolan, Ph.D., 181 pp., \$6.95, The C. V. Mosby Company, 1968.

THE PURPOSE OF this text is to promote technical excellence. It is concisely written and should achieve its goals.

Questions and Answers on Contact Lens Practice

By Jack Hartstein, B.S., (Med.), O.D., M.D., 199 pp., \$10.75, The C.V. Mosby Company, 1968.

AN EXCELLENT TEST for anyone interested in the practical application of contact lenses. ■



University of Hawaii.....

The Department of Psychiatry announced the appointment of **John McDermott, M.D.**, Professor of Psychiatry at Michigan, as Chairman of this department at the University of Hawaii, July 1, 1969. **Walter F. Char, M.D.**, will continue to serve as part time Professor of Psychiatry. He was recently awarded a \$23,887 grant by the National Institute of Mental Health, to fund a training program for psychiatry for medical students during the academic year 1969-70. On January 1, 1969, the psychiatric service of the Leahi Hospital became a University of Hawaii School of Medicine clinical service. An organizational meeting was recently held at the Leahi Hospital by child psychiatrists in Hawaii. This group will be meeting regularly and working for the advancement of child psychiatry in the Pacific Basin. Dr. Char has been appointed a member of the training committee of the Integrated Residency Training Program in Psychiatry in Honolulu.

The Section of Surgery announces the appointments of **Clifford Chang, M.D.**, Instructor; **Robert H. Oishi, M.D.**, Clinical Instructor; **Clarence Sakai, M.D.**, Clinical Instructor; **William Won, M.D.**, Clinical Instructor (neurosurgery); **William Davis, M.D.**, Clinical Instructor (urology); and **Roy Tanoue, M.D.**, Associate Clinical Professor.

In the Department of Pediatrics, **Sharon Bintliff, M.D.**, and **Walton K. T. Shim, M.D.**, have been awarded \$1,500 from a local trust fund for the study of racial incidence of biliary atresia in Hawaii. **Lowell M. Wiese, M.D.**, gave a lecture to an adolescent group entitled "Why I'm Confused About Sex." **Harry C. Shirkey, M.D.**, has recently been re-elected Vice Chairman of the Council on Drugs of the American Medical Association. He recently lectured to the Oregon Academy of General Practice on "Drug Reactions Related to Growth and Development."

The Section of Obstetrics and Gynecology has appointed part-time faculty members to carry out specific programs beyond the teaching duties expected of clinical faculty members. **John A. Krieger, M.D.**, Assistant Professor, directs the Joint Residency Training Program in Obstetrics-Gynecology; **Colin McCorrison, M.D.**, Assistant Professor, jointly with **Clare Sprague, M.D.**, Assistant Professor of Obstetrics-Gynecology and Pathology, are beginning a Pacific Basin Tropho-

blast Tumor Study; **Francis M. Terada, M.D.**, Assistant Professor of Obstetrics & Gynecology, is coordinator of Pacific Basin Maternal-Child Health Programs; **Millard Seto, M.D.**, Assistant Professor, is coordinator of Maternal-Child Health Programs in Hawaii; **William J. Natoli, M.D.**, Assistant Professor, Gynecologic Oncology and Radiation Therapy; **Richard Davi**, Instructor, Administrative Aspects of Obstetrics & Gynecology; **Eleanor Nordyke, R.N. M.P.H.**, Instructor, jointly with the East-West Center Family Planning and Population Program. On February 24 **Robert Noyes, M.D.**, and **John Krieger, M.D.**, attended the annual meeting of the Association of Professors of Gynecology and Obstetrics in New Orleans. The subject of the meeting being Residency Training Programs. Dr. Krieger's suggestion that annual workshops be held for all residency-program directors was received very favorably. On March 20 and 21, Dr. Noyes and **Colonel Jack Vaughn**, Chief of Service at the Tripler Hospital, attended the Society for Gynecologic Investigation in Denver, Colorado. Dr. Noyes was appointed to the Board of Directors for the Society.

On April 1, 1968, the first Planned Parenthood Clinic opened at the Queen Emma Clinics. This Clinic is to be manned by members of the Joint Residency Training Program in Obstetrics and Gynecology plus volunteer consultants from the Honolulu community on Tuesday and Thursday evenings. Dr. Noyes is Medical Director, **Charles Odom, M.D.**, is Associate Medical Director and **George Goto, M.D.**, is the Chairman of the Medical Advisory Committee of Hawaii Planned Parenthood. On April 9 and 10 Dr. Noyes attended the annual meeting of the American Association of Planned Parenthood Physicians at San Francisco.

In the Department of Anatomy, **Vincent J. De Feo, Ph.D.**, and **Milton Diamond, Ph.D.**, attended the 82d annual session of the American Association of Anatomists in Boston, April 1-4, and Dr. Diamond presented a paper entitled *Neonatal Progesterone: Effect on Reproductive Function in the Female Rat*.

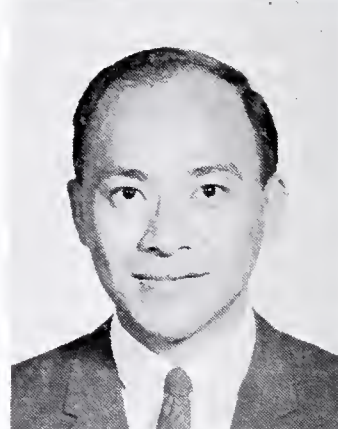
On April 15 a Continuing Health Education Council of Hawaii was created under the guidance of the Hawaii Medical Association. Eleven members were elected to the Executive Committee. ■



Walter S. Yokoyama, M.D.
1010 South King Street, Suite 503
Honolulu, Hawaii 96814
OTOLARYNGOLOGY
Northwestern University—1961
Internship—Lutheran Hospital,
Ft. Wayne, Indiana—1961-1962
Residency—Indiana University
Medical Center—1962-1966



Helen S. Percy, M.D.
Maui Medical Group
Lahaina, Maui 96761
GENERAL PRACTICE
Woman's Medical College,
Philadelphia—1958
Internship—L.A. County Harbor
General Hospital—1958-1959
Residency—L.A. County Harbor
General Hospital—1959



Roger I. Ogata, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
INTERNAL MEDICINE
Northwestern University—1958
Internship—Chicago Wesley Memorial
Hospital—1958-1959
Residency—Chicago Wesley Memorial
Hospital—1959-1964



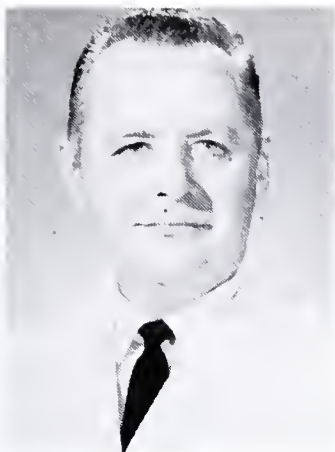
Charles W. Barnes, M.D.
1133 Punchbowl Street
Honolulu, Hawaii 96813
ORTHOPEDICS
Toronto University—1957
Internship—Hamilton General
Hospital—1957-1958
Residency—The Queen's Hospital—
1960-1962
Shriners', Springfield, Mass.—
1963-1964
Boston City Hospital—1964-1965



John N. Withers, M.D.
1827 Wells Street
Wailuku, Maui 96793
GENERAL SURGERY
University of Colorado—1959
Internship—Madigan Army Hospital,
Tacoma, Wash.—1959-1960
Residency—U.S. Army Tripler
General Hospital—1960-1964



John Peter Keenan, M.D.
1301 Punchbowl St.
Honolulu, Hawaii 96813
INTERNAL MEDICINE
University College—Dublin, Ireland
—1956
Internship—Jervis Street Hospital,
Dublin—1956
Ashford Hospital, Kent—1956
Hillingdon Hospital, Middlesex—
England—1956-1957
Residency—The Queen's Hospital
—1963-1966



William J. McLaughlin, M.D.
4568 Kuhui Street
Kapaa, Kauai 96746
Jefferson Medical College—1953
Internship—Lankenau Hospital—
Philadelphia—1953-1954

County Society News

Hawaii

Dr. Ray Gifford from the Cleveland Clinic was the guest speaker at the November 7 meeting. At the conclusion of the business meeting he presented a talk on "The Medical Treatment of Hypertension." A public hearing on proposed rules and regulations governing limited and temporary licenses was announced. It was voted to name Dr. Miyamoto's office as the message center for the HMA's WATS line. It was voted to have a meeting with the local members of the State Legislature to instruct them in the needs and equipment problems of the Hilo Hospital.

Dr. Windsor Cutting was a guest at the April 18 meeting. He gave an informative review of the current programs and future plans of the Medical School. Dr. DeWitt Hendee Smith's application for membership was approved. It was voted to send a letter to Dr. Quisenberry indicating support of Mr. Frank Keifer as Administrator of the Hawaii County Hospital Systems. A thank you letter from Mr. George Kina, one of the Society's scholarship recipients, was read. It was announced that five island students attended the Careers Day activities in Honolulu.

Honolulu

Approximately 145 members attended the February 4 meeting. One new member was welcomed into the Society, Robert DiMauro. Representatives from the American Association of Medical Assistants were presented. The new physician who has settled in the Waianae-Nanakuli area, Daniel H. Bessessen, was introduced. Dr. Mor McCarthy reported on the Disaster Committee's participation in several emergency alerts. A letter from Dr.

Robert Katsuki relative to the \$40.00 assessment was read. The Society's parliamentarian, Dr. Harry L. Arnold, Jr., reviewed the actions that led up to the approval and implementation of the assessment. The first and second year students of the University of Hawaii School of Medicine presented a program which was followed by a question-and-answer session.

Approximately 140 members attended the March 4 meeting. Three new members were welcomed into the Society: John Keenan, Roger Ogata, and Walter Yokoyama. Dr. Robert Miyamoto paid his official visit as President of the Hawaii Medical Association. Two announcements were made: The Chair urged all members to attend the Woman's Auxiliary AMA-ERF benefit on April 5 at the Kahala Hilton and Dr. Varian Sloan, HMA Secretary, urged all HCMS delegates and alternates to register for the HMA annual meeting to insure proper hotel accommodations in Hilo. The meeting concluded with a talk by Gordon Macdonald, Ph.D., on the volcanic activity on the Big Island.

Approximately 100 members attended the April 1 meeting. New members Eldon Smith, Richard Tesoro, and Quintin L. Uy were welcomed to the Society. Mrs. Donald Jones, Woman's Auxiliary President, reminded the doctors of the annual AMA-ERF benefit. The speaker for the evening was Dr. Donald P. Johnson, Professor of History at the University of Hawaii. He spoke on the "United States Policy in Asia." Dr. O. D. Pinkerton presented to the membership a report on the Foundation's operations and financial status.

Kauai

The November 5 meeting opened with a talk on Birth Defects by guest speaker Dr. Walton Shim. Letters were read relating to alcoholism, continuing education, Workmen's Compensation, home health services, and using nonfading ink for vital statistics records. Dr. Miyashiro reported on the HMA Council meeting. Three new members were voted into the Society: Drs. Rea, Mathews, and Ley. Collection was made of \$6.00 for RMP from Drs. Rames, Wallis, Chuang, and Takeuchi.

At the December 11 meeting Dr. Johnston reported on Aetna. He said that the accepted number of visits for acute cases would be once a day and the average number of calls for extended care and chronic patients would be once a month. Dr. Wallis reported that HMSA negotiations are at present at a standstill. Dr. Albert Johnston's number was selected for the WATS message center the HMA is setting up. Dr. Geroso reported on the dues structure. The following officers were selected for 1969: President, Albert C. Johnston; Vice-President, Gonzalo Geroso; Secretary-Treasurer, Charles Custer; HMA Delegate, Robert Emrick; HMA Alternate Delegate, Patrick Cockett. Dr. William J. McLaughlin was voted into the society contingent upon the report of approval from the full Board of Censors.

HMA President Robert Miyamoto and President-elect George Mills were guests at the April 8 meeting held at Kauai Resorts.

It was voted to refer correspondence relative to a speaker for the Governor's Conference on Alcoholism, and a visit from Dr. Robert Samp to the Executive Committee. It was voted to host the HMA annual meeting at such a time that a Kauai member be President of the HMA. This was also referred to the Executive Committee for final action and decision. It was noted that there were no committee reports and the balance of the program was turned over to the guest speakers. Dr. Miyamoto discussed the Physicians' Benevolent Fund and asked for suggestions. Dr. Mills spoke at fair length on the future projects during his tenure of office and specifically asked for everyone's cooperation on committees when requested to do so. ■

Professional Moves

The ancient oracles proclaim 1969 as the Year of the Rooster, but the Space Age prophets are calling it the Year of the Moon. Be it so, and we wish bon voyage to those opening their new offices. In February, allergist **Ray Allen** associated with the Fronk Clinic and **Daniel Bessessen** moved from Colorado to the MD-forsaken Waianae-Nanakuli area (thus capping the combined efforts of the Governor's office, the State Health Department and the Honolulu County Medical Society). In March, general and thoracic surgeon **Nathaniel Ching** joined the Dickson-Bell Medical Center and **Dick Lee**, Dean of the University School of Public Health, who was caught in a retirement benefit predicament, joined the Straub Clinic to practice General Preventive Medicine. In April, **Marcelino Avecilla** moved to the York International Bldg. and Ob-Gyn man **Harry Nakata** opened a Waipahu branch office at 94-801 Farrington Hwy. Also in April, **Bob Oishi** was sent by the Kuakini Hospital Board of Directors to the University of Washington School of Medicine for one year's training with Thomas Marchioro in liver, lung, and kidney transplantation.

Elected, Appointed, and Honored

On the national front, quiet, unassuming **T. K. Lin** was elected Secretary of the Board of Governors, American College of Cardiology, and our scholarly editor, **Harry Arnold, Jr.**, who is also Clinical Professor of Dermatology at the University of Hawaii Medical School, was elected to the Board of Directors, American Dermatological Association, for a five-year term. Hard-working **George Ewing** was named to the newly organized Accreditation Commission of the American Association of Medical Clinics. Sportsman **Richard You** was named Vice Chairman of the National AAU Weightlifting Committee and elected to the U.S. Olympic Committee. Likeable **Unoji Goto** was elected a Director of the American Heart Association for a three-year term, succeeding HMA President-elect George Mills.

On the local front, personable **Larry Wong** was elected President of the Hawaii Chapter of the American Academy of General Practice. Also elected were **Felix Laferty**, President-elect; **Fred Dodge**, Secretary; and **Harold Lawson**, Treasurer. Also on the home front, **Herbert Nakata** was retained as a consultant for the Regional Medical Program in Hawaii's Pediatric Pulmonary Program.

We know **Tom Fujiwara** to be "a man for all seasons" so his reputations as an international ladyslipper (Cypripedium) expert comes as no surprise. During the three-day All-Hawaii Flower Show at HIC in February, Tom and Henrietta needed a wheelbarrow to cart home their prizes for they won first prizes in the Best Hobbyist, Best Paphiopedilum, and Best Miniature exhibits.

Yuen Sang Seto, recently turned 70, was honored by 300 family members at the Hilton Hawaiian Village. Yuen is the proud father of six sons, three of them physicians and a fourth still a med student. **Millard** is in private practice; **Dudley**, a Lt. Col., is stationed at Tripler; **Dexter** teaches at Johns Hopkins; and **Anthony** is a 3rd year med student.

Micronesian Escapade . . .

Pathologist **Grant Stemmerman et al** travelled to the Trust territories and contracted tropical sprue? Midway through a lecture on diarrhea, Grant had to beat a hasty retreat to the nearest head. Pediatrician **George Nagao**, who is a careful fellow indeed, went to the extent of ordering a 20¢ iced tea every time he brushed his teeth. Unfortunately the ice in the tea was of unboiled water, and he soon suffered a similar fate. It is interesting to note that not one of our wise scientists, including **K. S. Tom**, **Masato Hasegawa**, and **Ben Tom**, bothered to take stool cultures, but immediately resorted to Lomotil and various antibiotics. . . . Tsk, tsk.

Inquisitive **Ben Tom** was curious about local diets. A native offered the information, "I eat dog . . . roast dog." Ben was not particularly impressed. But when the native said, "I eat corpse soup," Ben became bugeyed with excitement, envisioning some form of cannibalism. He learned that the local religious custom was for friends

THOMAS KEAY

1886-1969

Dr. Thomas Keay, a pioneer plantation physician of Hawaii, passed away March 20, 1969, at The Sequoias Retirement Home, Portola Valley, California, at the age of 87.

Dr. Keay was born in Glasgow, Scotland, in 1882 and moved to New Glasgow, Nova Scotia, Canada, in 1886. In 1907, he received his medical degree from McGill University, Montreal, Canada. He served in the Canadian Army in World War I.

In 1921, he came to Hilo, Hawaii and worked at Pepeekeo Hospital which served three sugar plantations—Pepeekeo, Honomu, and Onomea. He retired from medical practice in 1944 and moved to Santa Monica, California, with his family.

Dr. Keay was President of the Territorial Medical Association in 1937 and was a member of the Overseas Veterans of Hawaii. He was a 32nd degree Mason in the Scottish Rite and a member of the First United Protestant Church of Hilo. He was a member of Alpha Kappa Kappa Medical fraternity.

Dr. Keay is survived by his daughters, Mrs. Russell D. Albers of Piedmont, California, and Mrs. William Campbell of San Francisco; a granddaughter, Maile; a sister in Ottawa, Canada; and a brother in London, England. His wife, Mamie, passed away in Santa Monica in 1958.

HENRY S. DICKSON, M.D.

of a deceased to partake of a coconut milk drink which had been used to wash the deceased and which was referred to as "corpse soup."

Masato Hasegawa, who has a bent for swimming in tropical waters in the nude, refrained from entering the azure waters off these atolls, polluted by direct sewage disposal.

Members Speak Up

Throughout the year, we follow with great interest the continuous outflow from that prolific mind of **J. I. Frederick Reppun** on a multitude of subjects. In April last year, Fred felt a compulsion to write a long critique on the ethical aspects of abortion, which we feel is a classic. When the *Star-Bulletin* carried the text of the American Civil Liberties Union's statement on abortion (which called for the abolition of laws covering abortion, not just their liberalization) Fred took it to task. He quotes Justice Hugo Black, who denies that the Constitution grants to all individuals a constitutional right of privacy, and even brings forth the judgments of Aristotle, Hippocrates, the Hebrew lawgivers, and the Roman Tertullian. Fred says, "Modern times and modern medicine have affected the circumstantial factors, but are we so much wiser than the ancients, that we are ready to change basic principles? . . . In one sense, abortion-on-demand is a step towards acceptance of euthanasia. . . . Physicians are already subjected to pressures in this direction and are troubled enough with the ethical implications of the prolongation, the restoration, and the rejuvenation of life. . . . It is the body politic that must decide for itself, in these days, whether the ancient ethic against abortion is no longer a valid one." Fred suggests, "Abortions could be interdicted except by operators licensed to perform such, the therapeutic kind, under circumstances to be spelled out in regulations of the Health Department of the State. These regulations would be promulgated, and modified or changed from time to time, only on the advice of a citizen's committee made up of physicians, ministers, lawyers, and sociologists. . . . The Legislature will have the monkey off its back; the law will apply mainly to 'criminal' abortions; the problem of the ethic involved will be handed over to those most deeply concerned; and the moulding of the norms of society can occur henceforth outside the law."

In August, Fred wrote in "Dissent" after reading Dan

Inouye's speech on how to settle the Vietnam problem politically. "I think it is logical to conclude, after years of poring over millions of words reaching us from all sources North and South of the DMZ, that the determination of our opponents, individually and collectively, to persist in the face of overwhelming odds—unchallenged supremacy in the air, a kill ratio close to 1,000 per cent, and a massive geographical obliteration by us—that this dogged determination must be a spiritual force we had best respect. . . . Such sacrifice is never born of slavery or dictatorship; there must be a nationalism behind it; and the longer we keep pounding them, the more unequal we can make the military struggle, the more deep-down, forever-and-ever rage and unforgiveness will we engender in Southeast Asia, win or lose. . . . Our wise men should know that it is impossible to deal reasonably with a maddened, self righteous, and unbeaten enemy. . . . Why should North Vietnam initiate a cease-fire? I see no reason why they should . . . it is not they that have the lion by the tail—we do. . . . Based on ordinary inter-human relations, it is we, the powerful and overwhelming winners . . . who should initiate the cease-fire. . . . Neither you nor I have so little faith in our country that we need fear to give away a little bit of our sovereignty in order to have a world at peace under law."

Medical Anecdotes . . .

Harry Arnold, Jr., tells us of a poem about the female pathologist who fell in love with a dermoid cyst, with "such smooth hair, such exquisite skin, and simply heavenly rods and cones. . . ." Then ovarian tissue turned up!

Bridging the Generation Gap? We note with alarm that **Hunky Chun** has recently gone long haired on us, and **Fred Dodge** claims he fell asleep on the barber chair and woke up with his ringlets. Luckily the barber was practicing her hairdressing technique and did not charge extra. We noticed that Queen's intern **Richard Rentz** has shoulder length tresses, a British colonial army type mustache, and a high-pitched voice to match.

Don Marshall is looking smugly comfortable in socks and sandals again. **Ivar Larsen** corrected his left trigger toe a year ago and Don has subsequently developed two trigger toes on his right foot. He says, "Ivar wants to get busy, but I told him I was too busy" (and, may we add, more comfortable!).

Of Dogs and Men. The story is repeated of **Marquis**
continued page 404

JOHN WILLIAM DEVEREUX, M.D.

1908-1968

Dr. John William Devereux, 60-year-old general practitioner, died at his home, October 15, 1968, after a prolonged cardiac illness. Born in Fort Bragg, California, while his parents were visiting on the mainland, he had been a resident of Honolulu since early infancy. He attended Punahou School, the University of Hawaii, and Stanford University. His medical education was obtained at the University of Chicago and Rush Medical College, where he received his M.D. degree in 1934. After a two-year internship at Chicago's St. Luke's and Presbyterian Hospitals, he returned to Honolulu to enter private practice. From 1935 to 1936 he served as assistant City and County Physician and from 1936 to 1939 as assistant medical director of Palama Settlement.

In 1941 he helped in establishing the Honolulu Blood Bank, and became its manager. He was also instrumental in securing legislation mandating premarital examinations and blood tests. For these and other outstanding community services, in 1942,

he was awarded the Junior Chamber of Commerce nomination as Man of the Year in Medicine.

He served on numerous committees of the Hawaii State and Honolulu County Medical Society, serving the latter as its President in 1951. He was also a former chairman of the Mayor's Advisory Committee on Indigent Medical Care, and former member of the executive committees of the Oahu Society for Crippled Children, the Salvation Army, the School Health Advisory Board, and the former Board of Hospitals and Settlement.

He was a member of the Republican Party, the Masonic Lodge, the Aloha Temple Shrine, and the Honolulu and American Orchid Societies.

Dr. Devereux is survived by his widow, Dorothy, a Representative in the Hawaii State Legislature; his mother, Mrs. Florence A. Devereux; three sons, John W. Jr. of San Marino, California, and Marvin and Fred, of Honolulu; and a daughter, Mrs. Phillip (Diane) Bayles of Minneapolis, Minnesota.

HOMER M. IZUMI, M.D.

COUNCIL MEETING

April 23, 1969 — 6:00 P.M.

Oahu Country Club

PRESENT

Robert M. Miyamoto, presiding, Drs. Batten, Chinn, Fong, Iaconetti, Jones, Lowrey, Mills, Richardson, Sloan, plus Drs. Goto, Oren, B. Tom, K. S. Tom, Tomita, and Mr. V. Thomas Rice and Mrs. P. H. Liljestrand, Mrs. R. V. Sloan, and Mrs. Charles Yamashiro.

MINUTES

The minutes of the January 22, 1969, meeting published in the March-April issue of the JOURNAL were approved as circulated.

LETTER OF RESIGNATION

Dr. Frank Bruce wrote a letter of resignation as a member of the Finance Committee and Communicable Disease & Immunization Committee.

ACTION:

It was voted to accept Dr. Bruce's resignation with regrets and that a letter be written to him.

It was pointed out that with the resignation of Dr. Bruce there will only be four nondesignated members on the Finance Committee and the Bylaws state there shall be five who shall be elected by the Council from nominees presented by the President of the HMA.

ACTION:

It was voted to appoint Dr. John Lowrey to the Finance Committee.

LEGAL COUNSEL TRAVEL

The Council was requested to approve travel expenses for the legal counsel to the annual meeting in Hilo.

ACTION:

It was voted to approve travel expenses for the Legal Counsel to Hilo, Hawaii and that Counsel should be present when the House of Delegates convenes on Wednesday, May 21, at 1:00 p.m. and stay until the time the House of Delegates ends its deliberations.

MEDICAL CARE COSTS MEETING

A report of the AMA 3rd National Congress on Socio-economics of Health Care was received from Dr. Joseph Oren. His report was circulated to members of the Council for review and comment.

ACTION:

It was voted to accept Dr. Oren's report.

MEETING ON HEALTH CARE COSTS

A letter from Mr. Richard E. Hager, Chairman, State Advisory Council for Comprehensive Health Planning, was received on January 30. His letter noted that at a San Francisco meeting on medical care costs a recommendation was made that each State attempt to follow up with a statewide conference on medical costs within its own jurisdiction.

A meeting was held on April 21 and 22, 1969, at the Ilikai Hotel in order that labor, management, and providers of care could get together. In the discussion of the conference Dr. Oren stated that he got more out of this

local meeting than he got out of the national meeting which he recently attended.

It was suggested that a meeting be set up with Mr. Stephen Murin of UPW and that it include Mrs. A. Q. McElrath of ILWU.

ACTION:

It was voted to accept and place on file Mr. Hager's letter.

HMA'S REPLY TO MR. ALBERT YUEN'S LETTER

It was noted that Mr. Yuen of HMSA wrote the HMA requesting an informal discussion of seeking ways and means to curb or level off the rising costs of medical care. The Council at its January 22 meeting voted to select an appropriate day in February and set up a meeting with representatives of concerned community agencies. The acceptance of this proposal was relayed to Mr. Yuen. It was suggested that Mr. Yuen's request was answered by the April 21 and 22 meeting on health care costs.

ACTION:

It was voted to accept and place on file HMA's letter of January 30 to Mr. Albert Yuen of HMSA. It was also voted to advise Mr. Yuen that the meeting of April 21 and 22 has answered his request.

FEBRUARY 14 REQUEST FOR COMMENTS

A memorandum voted February 14 was circulated to Councilors, Commissioners, and the Chairman of the Bureau of Research and Planning relative to articles of interest—(1) Hospital Fees Going Up [*Maui News*, Feb. 25], (2) Carvalho Resists State Takeover of Maui Hospitals [*Star-Bulletin*, Feb. 13], (3) Finch Dropping Chief of Children's Bureau [*Washington Post*, Jan. 24], and (4) Health Care Costs Target of Unions [*San Francisco Chronicle*, Jan. 29].

ACTION:

It was voted to accept these items of interest and place them on file.

RMP REPORT FROM DR. RICHARD D. MOORE

The report of March 27 on RMP by Dr. Richard D. Moore was circulated to the Council. It was pointed out in the report that the HMA could have direct representation upon request. It was recommended that the Council request the grantee institution to appoint three representatives of the HMA to the RMP. There are two methods of doing this; either by appointment of the HMA physicians already serving on the RAG or by appointment of additional members. It was also recommended that a committee be established within the Bureau of Research and Planning and charged with the responsibility of insuring adequate communication with the designated HMA representatives to RMP.

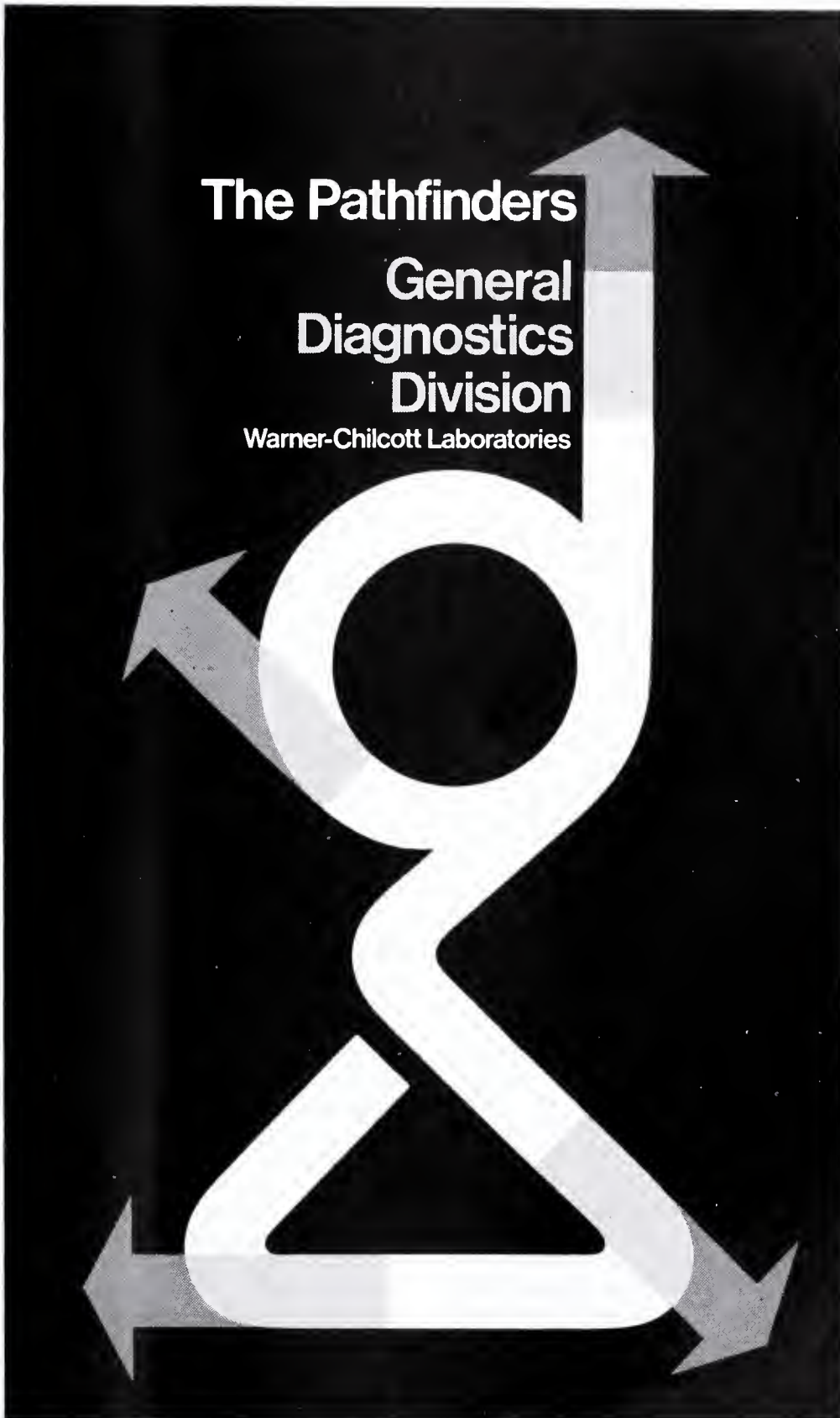
Dr. Mills reported that the HMA will be able to appoint an individual to the RMP Executive Committee and asked the Council to give some direction how this individual should be selected. This particular individual must prepare himself to come to meetings every Thursday morning at 7:00 A.M. Dr. Mills explained that Mr. Richard Davi is Chairman of the Executive Committee, Dr. T. Nishigaya is Vice-Chairman, and Dr. Mills is a member. All are appointees of the Governor. Dr. Mills stated that if the Council were to select another individ-

continued page 417

The Pathfinders

**General
Diagnostics
Division**

Warner-Chilcott Laboratories



HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: EDITH G. EKSTEIN, MT(ASCP), U. S. Army Tripler General Hospital

Your Officers—1968-69

President, James Yano, MT(ASCP); *President-elect*, Elizabeth Hughes, MT(ASCP); *Recording Secretary*, Diane Ogasawara, MT(ASCP); *Corresponding Secretary*, Jeanne Otake, MT(ASCP); *Treasurer*, Deanne Horie, MT(ASCP); *Board of Directors*, Gilbert Gima, MT(ASCP); Ronald Miyakawa, MT(ASCP); Patricia Taylor, MT(ASCP).

Travelling Techs

Where do med techs go when they want new ideas to infuse into old jobs? Apparently they go to the mainland—almost anywhere on the mainland. We have here a list of some of the recent HSMT travellers. If we missed you it's because you didn't tell us.

The year really starts in June for med techs in Hawaii, and June of 1968 was the time that Louise Wulff (U of H) and James Yano went to Houston to represent HSMT at the annual ASMT convention. Besides attending seminars on Personnel Relations and on The Teaching Medical Technologist, Louise worked on the reference committee which deliberated future plans and policies. This was Louise's fifth ASMT Convention.

Jim participated in management workshops and was Hawaii's representative in meetings of the President's Council. Both Jim and Louise were members of the House of Delegates.

Jim is now at the University of Hawaii where he joins Dorothy Matsuo, who preceded him by several months, in the Master's program in Public Health. Noreen Kawamura (HSMT's Treasurer, who left town before she got the treasury) is also pursuing a Master's, at Northwestern.

Pat Taylor (U of H) and Ann Stegmaier (Blood Bank of Hawaii) attended the AABB meeting in Washington, D.C., last October. In February of this year Lorene Leong and Phyllis Sonoda (both of Queen's) went to San Francisco for the Continuing Education Seminar on "Automation and Data Processing in the Clinical Lab" which was sponsored by the University of California School of Medicine.

In January Grace Kagawa (Straub), Ken Sato (Pathology Associates), and Mary Nakamura (Kaiser) went to Miami for the Coulter Counter Model F training course. Grace stopped off at CDC as part of Straub's Cardiac Club project and also at a St. Louis allergy lab to study nasal smear cyto-

grams. Then she met Gertrude Ching (Children's) at the Interim Meeting of ASCP where they participated in workshops on enzymology, immunoelectrophoresis, and spectrophotometry. It seems necessary to add that at the time of this writing Grace Kagawa is back in Honolulu.

Also at the time of this writing Takeyo Saito (Tripler) is packing for a May trip to Chicago for a cytology tutorial. Betty Hughes (State), Louise Wulff, and Edith Eckstein (Tripler) are planning to pack for the ASMT meeting in Philadelphia.

Not all med techs go east, however. Mary Beth Heustess was in Honolulu in March with the seminar version of the AABB Component Therapy Workshop. Also in town in March were vacationers Beverly Buckner and Narcissa Hocker, President-elect and Secretary of the Indiana Society of Medical Technologists, and Beverly Lowden, Editor of the ISMT publication *The Funnel*.

From The Mail

HSMT's President and Publications Chairman receive publications from about 25 other states. They vary from 50-page journals which include scientific articles and considerable advertising to four- or six-page mimeographed newsletters without advertisements. The latter seem to be more functional, as well as easier to read.

Among the journals received recently is a very handsome issue from one of the largest state societies. In addition to its artistic cover it contains ten pages of advertising, one page of contents and officers' names, two and one-half pages of ASMT material, and six pages of news of society activities.

In contrast, another journal devotes ten of its 28 pages to advertising, three to ASMT and NCCMT news releases, six to "news" releases from various laboratory supply firms, one and one-third pages to genuine news, and the rest to a variety of space fillers.

From reading one learns that the New Jersey Society's quarterly publication, heretofore *The News Letter*, is now *The NJSMT Analyzer*. The *Illinois Newsletter* for January-February, 1969, contains minutes of "the Inter-laboratory Society Committee" meeting held January 19. Present were representatives of the Illinois Association of Clinical Laboratories, American Medical Technologists-Illinois Society, Illinois Association of Bioanalysts, and Illinois Medical Technologists Association.

Northern High-Lights (Alaska Society of MT), February, 1969, reports that 14 persons attended

the Society's November meeting in Anchorage but the host group (from Doctors' Clinic) could not be present "because of the flu."

The interim Board meeting of the Michigan SMT featured a guest speaker: Martha Winstead of the ASMT Board discussed ASMT, ASCP, and their relationship to Medical Technologists.

Message From The President

DEAR MEMBERS OF HSMT:

Time is indeed a most precious commodity. It seems as if it were just yesterday that the present officers of HSMT were installed, and yet within a few months, the 1969-70 officers will take office.

In reviewing our past administration, did we achieve the aims and objectives that were set forth a year ago? Were our programs implemented to accomplish any worthwhile ends? Were our budgeting procedures revamped and modified for better fiscal responsibility? How effective are our continuing educational projects? Were any innovations attempted? Did our organization actively engage in community projects?

Let us make an objective evaluation of HSMT during the past year. In this manner we can redesign our goals by continuing the more successful programs, by modifying the static projects, and initiating newer or different approaches and plans.

Membership: Without growth in membership, a society becomes stagnant. Within the past year an intensive recruitment was carried on by both the national and local organizations. According to our records of last June, HSMT had a total of 93 members (includes active, associate, and student members). This year, as of February, 1969, we have a total membership of 107 members. With a conservative and realistic estimate of eight to thirteen additional medical technologists joining our group by June, 1969, our growth rate in membership will be 25 to 30 per cent over 1968.

Community Activities: The Health Fair in October of last year was a tremendous success. The HSMT booth—well recognized, well organized, well coordinated, and well staffed—passed out educational and recruitment literature and processed thousands of fairgoers in diabetic screening procedures.

We are scheduled to participate in the forthcoming High School Career Day, the Cancer Society's educational program, and the newly formed advisory council of Allied Health Professions of the Continuing Health Education Council.

Convention: The HSMT convention committee is finally daring to schedule our 1969 annual convention for Lahaina, on the Valley Isle; Maui. The committee began planning the mammoth undertaking seven months ago. Enthusiasm and support for this adventure is great! Preliminary

applications for reservations are most encouraging and the most entertaining, relaxing, and memorable convention ever is predicted.

Budgeting: At the beginning of the fiscal year, each officer, board member, and committee chairman was allotted a budgeted sum of money for the year. At the end of their terms of office, recipients of funds will submit an itemized list of expenditures to the treasurer for accounting, auditing, and filing.

Scholarship Fund Drive: The scholarship fund drive, held yearly at Christmas time, was once again a great success. Hard work on the part of the committee and candy-selling members did it.

Continuing Education: Under the auspices of the University of Hawaii and at the request of the HSMT Committee, an evening 3-credit course in immunology was presented. It was challenging and rewarding.

Official File of HSMT: With the approval of the executive board, a four-drawer, 8½ x 11" file cabinet, with lock, was recently purchased and installed at the Blood Bank of Hawaii. This filing cabinet will centralize records for the officers, board members, and committee chairmen of HSMT.

Others: Active, ongoing programs are being carried out by our other committees. All of them help keep HSMT going and growing.

Fearful of inadvertent omissions, I have left out specific names in this article. Needless to say, however, HSMT is greatly indebted to countless dedicated and conscientious members who gave endless hours of valuable time. We are very grateful for their commitment to the programs and projects of our professional organization because only through these routes are real growth and stature attainable in our organization. Be mindful, however, that criticism, negative attitudes, lethargy, and pessimism will only negate the more positive contributions of our group.

The future appears most promising for our profession of medical technology; therefore, let us be prepared to undertake the challenge and be worthy of being called "professional" in the allied health field. Set specific goals, plan and organize programs, keep within fiscal restraints, obtain commitment and involvement, and, above all, separate objectivity from subjectivity to accomplish the goals of our organization.

In closing, I would like to extend my sincerest thanks and appreciation for the honor of being the President of the Hawaii Society of Medical Technologists for the past year and to also extend the same gratitude to all the officers, board members, committee chairmen, and the entire membership of HSMT for their support, patience, guidance, and dedication.

JAMES YANO, MT(ASCP)
President ■

Stevens' dog who slept while burglars took the family's TV sets, not once, not twice, but at least three times that we know of. **Paul Tamura** has had his Diamond Head home entered several times, so he has acquired a large dog of unknown ancestry who habitually breaks his chains. His daughter Cheryl takes "Corky" to the dog-training course and in one demonstration (where he was supposed to jump through a loop held by Cheryl) he miscalculated and collided headlong with her. Not bright, but a good watch dog nevertheless. The **Noboru Oishis** have a pit bull (a vicious-looking monster) who gives Noboru wrestling matches when going through obedience classes.

Derm Conference

Harold Johnson gives scabies its notch in history. It seems that Napoleon's Army did not do so well on the battlefields because it was up half the night scratching. Harold feels that even the familiar pose of Napoleon with one hand tucked in his tunic was prompted by the need for scratching. **Norman Goldstein** informs us that topical occlusive steroid dressings will sharpen tattoos and recommends Cordran tape for the "teeny weeny Bikini syndrome." He has also found the tape excellent for repairing dings on surfboards. **Ed Emura** sends us the message that we should not treat all fungi-looking lesions with griseofulvin, but take scrapings or cultures first. . . .

Medically Speaking . . .

During one of the monthly TV Committee meetings which plans future programs, **Claude Caver**, who sports an enviable full copper-red plume, looked mischievously at our thinning pates and suggested the whimsical topic: "Man's Oldest Fallout Problem."

The "Drug Abuse" program with panelists **Don Char**, **Fred Dodge**, and **Lt. Fee** (of our Police Dept.) was being sorely beset by marijuana users who wanted the law liberalized. One sultry female voice called in, "I'm stoned. . . . How can you say such things about marijuana. . . . It's wonderful. . . ." A male caller with a slight stutter gushed, "Have you ever t-t-tried D-D-MT? Boy. . . . It's a real brain sucker. . . ."

Bob Kim, **Vie Hay Roe**, and **Lester Yee** were having a field day with "Lumps and Bumps." A caller asked, "What do you do for bunions?" Dermatologist **Bob Kim** answered matter of factly, "I refer them to an orthopod." Question Central **Hugh Lytle** looked twice at the question: A "13-year-old Aiea girl" asks, "Are infected males dangerous?" He judiciously withheld the question and after the program showed it to **Claude Caver** who roared, "I wrote 'infected mole,' not 'male'."

The adage, "The show must go on" holds true for troupers like **Don Jones** who showed up for the program, "Spare Parts" with fellow orthopods **Don Maruyama** and **John Smith**. Don looked a little peaked because of a diagnostic Vim-Silverman needle biopsy on his own liver earlier that day, but showed no other ill effects except that he did crouch forward with a somewhat effective pained expression during the program. A percipient viewer complained, "Please tell Dr. Jones to sit up straighter in his chair if he wants to avoid a backache. Anyway, that's what *he* tells *me*. . . ."

Picturesque Speech

ENT men nowadays are a loquacious breed. Not only do they call themselves such tongue twisters as "oto-rhinolaryngologists," but we recently excerpted this from an ENT colleague's report: "I hope to clear Randy's otitis media by medication and politerization. . . ."

From **Ed Childs** we gleaned that "proctologists build their houses on piles" and that "ENT men have mastoid

manors and tonsil terraces." Ed swears that the following is a true story. A man went to a doctor with perianal pain and later bragged to his friends that his doctor had told him that he had a "supernatural anus." (Later confirmed to be a superficial abscess.) Ed also tells the story of a woman intern who while describing a lesion of the glans during a path conference kept referring to it as "a lesion of the proximal penis." The prof corrected her, saying that it was really "a lesion of the distal penis," whereupon the intern retorted, "Sir, it may be distal to you, but it is certainly proximal to me. . . ." (A point of view.)

Doctors in Print

Ralph B. Cloward, "Congenital Spinal Extradural Cysts: Case Reports with Review of Literature," *Annals of Surgery*, v. 168, No. 5, pp. 851-864, 1968 (November).

C. F. Aquadro, et al, "Sur les Limites Physiologiques de la Plongée a Saturation à l'Air et aux Melanges Synthétiques," *Revue de Physiologie Subaquatique et Médecine Hyperbare*, Tome 1, number 1, Mar.-Apr.-May, 1968.

The July, 1968, issue of *Geriatrics* is entitled "Straub Clinic Symposium" and includes the following eight papers: **Reginald Ho**, "Disorders of Iron Metabolism in Geriatrics"; **Edwin Gramlich**, "Recognition and Management of Grief in Elderly Patients"; **Robert Kistner**, "Management of Severe Leg Ischemia in the Elderly Patient"; **D. R. Grininger** and **R. G. Rigler**, "Lymphatic Metastases from Paget's Sarcoma"; **J. E. Strode**, "The Large Intestine as a Geriatric Problem"; **H. William Goebert, Jr.**, "Ruptured Cerebral Aneurysm in the Older Patient"; **Harry Arnold, Jr.**, **R. M. Williams**, and **Robert Kim**, "Topical 5-Fluorouracil for Actinic Keratoses"; and **L. Clagett Beek** and **Esther K. Stangle, M.A.**, "Geriatric Rehabilitation."

Sportsmen

Golf: The annual DDD Golf Tournament was held as usual on an April Thursday at Francis Brown Golf Course, where intermittent squalls and gusty winds kept even the hardy busy putting on and removing their rain jackets. **Mike Okihiro** complained that while putting on one green, the wind he was bracing against stopped suddenly and he nearly fell forward on his face. We watched with amazement as **Glenn Kokame** sliced his very first drive into an OB stake and the ball ricocheted back in bounds. From some of the scores turned in, we assume that as many strokes were spent on those fast-breaking wind-swept greens as getting there from the tee. We must not forget to thank eagle-eyed **Tom Riebert**, who perched himself on the hill overlooking the doglegging 5th hole and spotted all balls landing in the rough to the left, thus saving us many strokes in lost balls. The fast greens, the narrow fairways sprinkled with ample water hazards and OB's, and the inclement weather took their toll of our pretournament favorites like **Don Maruyama**, **Mike Okihiro**, **Hideo Oshiro**, **Frank Fukunaga**, **Ed Izawa**, **Paul Tamura**, and **Toots Fujii**. Even last year's champ **Masaru Koike** had a net 73 with his 25 handicap. **Art Saleedo**, who has the smoothest left-handed swing west of the Rockies, had a net 73 with his 30 handicap. But **Bill Dang** and his 29 handicap came in with a net 68 to tie with 15-handicapper **Joe Nishimoto** for first place. In third place was perennial winner **Francis Soon** with a net 70 and tied in fourth place were **H. Yokoyama** and **Richard Ho** with net 71's. Dick, having scored in his first tournament, was simply ecstatic. Our real hero of the day was **Al "Bozo" Chun** who shot a gross 77 with his 15 handicap and won over-all low net. (Bozo claims he couldn't do anything wrong.) But still, our MD team placed last as usual, with the dentists winning first place and the pharmacists second, so once again the Perpetual Trophy went to the winning dentists. We implore some of our better physician golfers like **Mae Mitsuda**, **Roy Tanouye**, **Al Ho, et al** to sign up next year and uphold our honor.

On our individual matches, when **Paul Tamura** began to post six pars in a row on the second nine, we began to wonder how we were faring. We had the temerity to ask **Toots Fujii**, Paul's partner, how we stood, and subtle comedian Toots promptly replied, "Bow-legged and wobbly. . . ."

We do thank the pharmacists and their Tournament Chairman **Richard Yoshino**, who arranged the excellent cuisine at the Kanraku Tea House and the duo of exotic dancers from Forbidden City. The MC cackled, "I don't understand how you doctors can get excited over a strip show you don't even get paid for."

Psychiatrist **Jim Harrison**, who golfs with a plastic helmet to protect his valued noggin, won Low Net for the nonhandicappers with a net 68. When Jim was not present to receive his prize, the MC commented, "He lied so much about his score that he is not here to receive his award." In fourth place for the nonhandicappers was **Bill Stevens** and in fifth place **Ed Kagihara**, both honest men who can vouch for Jim's score. . . .

The traditional African golf game which followed the entertainment was apparently disbanded early for lack of investment funds when **Roy Iritani** threw over ten passes in a row, thus making up for his poor day on the course. Yet **Joe Nishimoto**, who had tied for first place, is reported to have been one of the over-all winners during the evening session, so his luck apparently held.

One memorable Saturday afternoon at the Mid Pac Golf Course, **Paul Tamura**, who is usually a careful driver, made a sudden left turn on the ninth hole to avoid an obstruction. He noted a sudden lightening of the cart and the lack of an answering grunt from his fellow passenger **Herb Takaki**. He turned around in time to see Herb sprawled on his okole, clenched fists waving menacingly and sputtering on such words as only Herb is capable of.

On April 5, **Mike Okihiro**, who attributes his 11 handicap to a computer breakdown, shot a gross 75 and won the monthly ace, and team best balls in 1st, 2d, and 3rd

places (two of his partners were **Herb Takaki** and **Don Maruyama**). **Art Salcedo** also won his share of honors that same weekend, to the tune of \$40.

Orthopod "**Buster**" **Richardson** recently walked into the WCC locker room sporting a turtle-neck sport shirt which gave his neck a Thomas Collar look. Commented **Bill Ito** wryly, "When did you get whiplashed?"

Queen's Conference

During a panel discussion on heart blocks, the panelists were fairly evenly divided on the purely academic question, "to use or not to use" anticoagulants in the face of a friction rub. When asked to cast a deciding vote, Queen's medical director **James Orbison**, who had been a career military physician until recently, complained, "After spending half my life in a militant situation, I find myself in yet another militant situation." Quipped **Ed Chesne** rather militantly, "We have a militant situation in heart blocks, and we have to take a militant approach. . . ."

Visiting Physicians

We had an inkling of the conceit and abrasiveness of Japan's foremost cardiac surgeon, **Toshiro Wada**, when *Star-Bulletin* medical reporter **Tomi Knaefler** told us she had had a run-in with him, but we were not quite prepared for the *yamato damashii* (literally, Japanese spirit) he exudes. Toshiro is a stout, crewcut, boyish, facial contortionist who speaks English well enough to produce puns, but has typical difficulty with pronunciation of "l's" which came out as "r's." So much so that we listened for an hour before we discovered that the mysterious "prostatic valve" he kept referring to was really a "plastic valve." He spoke at length about the superiority of his Wada Hingeless Teflon Valve over other types of valve

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The next time
you treat a patient
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THE SPECTRE OF RECURRENCE



Up to 80% recurrence of bacteriuria: a need for long-term suppressive therapy?

You can readily clear the urine of bacteria and control the acute phase of urinary infection with specific antibacterial therapy. But is that enough? Continuing reports on the high rates of recurrence (80% in some cases¹⁻³) suggest that it is not.

A growing number of clinicians now feel that immediately after the control of the acute phase in patients with a history of recurrence, long-term suppression of bacteriuria should be considered and may provide a greater measure of success.

Many clinicians have found Mandelamine helpful in preventing recurrences and fulfilling the need of long-term suppressive therapy.

Mandelamine reduced recurrences in adult males³

The interim results of a continuing study in seven U. S. Public Health Service hospitals demonstrate that long-term treatment with urine sterilizing agents can control recurrence of bacteriuria in adult males. However, long-term therapy was only effective if initial sterilization of the urine was achieved with broad-spectrum antibiotic therapy.

In this study such antibiotic therapy eradicated bacteriuria in 88 percent of 122 patients. Then each of these 107 patients was placed randomly in one of four groups. After 13 months the recurrence of bacteriuria rates was 86% for the placebo group, 46% for the nitrofurantoin group, 43% for the sulfamethizole group and 22% for the methenamine mandelate (Mandelamine) group*.

*In this group, the greater interim use of antibiotics for incidental infections, and minor variations in distribution of patients as to adverse host factors, may have contributed to the better response.

Mandelamine has also been shown to reduce recurrences in children⁴ and to be of value in the treatment of bacteriuria associated with chronic infections.⁵

Mandelamine— a logical choice

There has been increasing interest in the use of long-term suppressive therapy, although the benefits are not yet fully established. In each case, the physician must decide, based on the history of recurrences, whether he wishes to institute long-term bacteriuria control. When the decision is made to utilize such therapy, Mandelamine is a logical choice.

When utilized immediately after antibiotic therapy, Mandelamine, in conjunction with a urinary acidifier (if necessary) is a useful agent in preventing recurrences of bacteriuria. Through its local action in the urine, Mandelamine exerts its antibacterial effect against a wide range of gram-negative and gram-positive pathogens. Unlike sulfonamides and antibiotics, it does not foster development of bacterial resistance. And Mandelamine offers the safety margin and economy so important in long-term use.

Q.i.d. dosage

Since the methenamine class of drugs is rapidly excreted, a *q.i.d.* dosage of Mandelamine is recommended for a more continuous level of the antibacterial agent in the urine.

1. Mod. Med., 34:109 (April 11) 1966. 2. The Kidney, ed. 3, Boston, Little, Brown & Co., 1967, pp. 286-291. 3. Ann. Int. Med. 69:655 (Oct.) 1968. 4. Am. J. Dis. Child. 105:560 (June) 1963. 5. Hosp. Med. 4:73 (May) 1968.

Description: Mandelamine (methenamine mandelate), a urinary antibacterial agent, is the chemical combination of mandelic acid with methenamine.

Indications: Mandelamine (methenamine mandelate) is indicated for the suppression or elimination of bacteriuria associated with pyelonephritis, cystitis and other chronic urinary tract infections; also for infected residual urine sometimes accompanying neurologic diseases. When used as recommended, Mandelamine (methenamine mandelate) is particularly suitable for long-term therapy because of its safety and because resistance to the nonspecific bactericidal action of formaldehyde does not develop. Pathogens resistant to other antibacterial agents may respond to Mandelamine (methenamine mandelate) because of the nonspecific bactericidal effect of formaldehyde formed in an acid urine.

Contraindication: Contraindicated in renal insufficiency.

Precautions: Dysuria may occur (usually at higher than recommended dosage). This can be controlled by reducing the dosage and/or acidification.

When urine acidification is contraindicated or unattainable (as with some urea-splitting bacteria), the drug is not recommended.

Adverse Reactions: An occasional patient may experience gastrointestinal disturbance or a generalized skin rash.

Dosage and Management: The average adult dose is 4 grams daily given as 1.0 Gm. after each meal and at bedtime. Children 6 to 12 should receive half the adult dose and children 5 years of age or under should receive 250 mg. per 30 lb. body weight, four times daily. Since an acid urine is essential for antibacterial activity with maximum efficacy occurring at pH 5.5 or below, restriction of alkalinizing foods and medication is thus desirable. If testing of urine pH reveals the need, supplemental acidification should be given.

Supplied: 1 Gm. Tablets (Unogram™), 1.0 Gm., purple enteric coated, bottles of 100 and 1000. ½ Gm. Tablets (Hafragrams®), 0.5 Gm., brown enteric coated, bottles of 100. ¼ Gm. Tablets, 0.25 Gm., brown enteric coated, bottles of 100.

Full information is available on request.



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prostheses. When local cardiac surgeon **Niall Scully** fell into a neat trap and inquired about suturing technique, he showed a color movie demonstrating the Wada knotless technique for sewing heart valves with a continuous Teflon suture. (He repeatedly emphasized that "knotless" was not spelled "nutless" and we have every reason to believe that this was meant to be a pun.) "What is hingeless?" he asked himself. "A doctor from Hawaii came to Hokkaido and learned what hingeless meant after drinking much SAKE . . ." He cackled with delight at his own joke when the audience was a bit slow on the uptake. "With our typical Japanese ingenuity, we have developed a portable hyperbaric tank. The same Japanese parachute company which makes your Apollo space suits makes this tank." He did concede, however, that his Teflon valve was being manufactured by our Cutter Laboratories. All this vanity we should have anticipated when he introduced himself as "I'm a humble chipmunk hopping around the world—starting at Capetown where I . . . and I . . . and I . . ." et cetera, et cetera . . .

Tall, white-domed, cherub-faced **Wade Volwiler** from the University of Washington was the Queen's Visiting Professor of Medicine for two weeks in February. Wade speaks slowly with a soft, well-intonated voice like a preacher's, and his lectures on gastroenterology were informative and rewarding.

Re bland diets: "There is no scientific evidence of any kind that bland, anorexia-producing, unpalatable foods, with their glue-like consistency, are helpful in treating ulcers. . . . The good ole dictum has been 'Don't eat anything tasty'. . . . Even with spices, secretory studies have shown no effect. . . ."

Re our general ulcer regimen: Wade ruefully commented, "It seems that we encourage patients to stop eating anything that is tasty and to stop anything that

is fun. . . ." He did condemn alcohol and caffeine, however, and **Doris Jasinski** (who is usually campaigning against something) quickly asked, "How about smoking?" The answer was terse: "The data are fragile and I don't discuss this with my patients. . . ."

Re the use of stilbestrol in duodenal ulcer therapy: "The results are unremarkable, but the side effects are impressive. . . ."

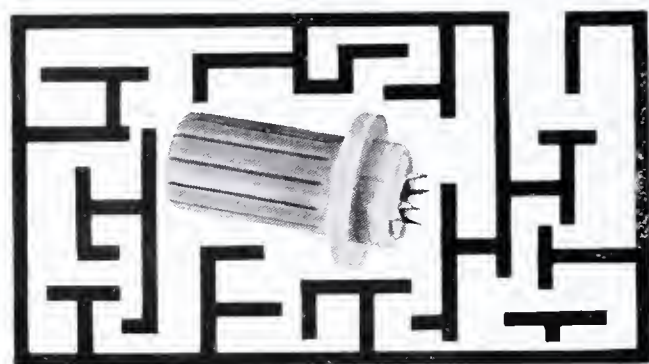
Surgeon **Lester Yee** demanded impatiently, "How do you define an intractable ulcer and when do you call in a surgeon?" His enigmatic answer was, "When it begins to threaten life's complications. . . ."

Re shunt surgery for bleeding esophageal varices: "One of the major problems is whether to shunt or not to shunt. . . . A three-year series by a Boston group shows no difference. There is no point in doing shunts prophylactically, ever, just to save the blood bank. . . ."

Utah's M.D., Ph.D. **Homer Warner** was Visiting Professor of Medicine at Queen's in December. We listened in awe as this bespectacled, athletic, deep baritone with a computer mind described how we have barely scratched the surface in the use of computers in medicine. We felt reassured that humans were still in control when Homer described how 50 man-years had already gone into the study of the QRS wave alone, but computers still have difficulty recognizing even the simplest wave patterns. But then he cautioned, "Right now, the computer cannot replace a good cardiologist for detecting arrhythmias, but this is only a matter of time. . . ."

We listened attentively to **Ivan Duff** from U. of Michigan's Rackham Arthritis Research Unit who gave a series of four meaty lectures at SFH in January. Ivan, we discovered, was the same genial scholar with a well-modulated voice we knew back in med school, and the wealth of information he imparted required no risqué humor to hold our attention. We met him at the Francis Oda's Top of Waikiki gathering for Michigan alumni and others, and had a nostalgic session on our burgeoning Alma Mater in good ole Ann Arbor.

continued page 412



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A specific solution for tinea versicolor

Although tinea versicolor is not a serious disease it is chronic and recurrent and specific treatment is cosmetically important. "Of the wide variety of compounds recommended for the treatment of tinea versicolor, sodium thiosulfate still remains the standard."* However, when sodium thiosulfate is administered alone it decomposes rapidly and produces an offensive odor. These disadvantages have been largely eliminated by the development of TINVER Lotion, which contains sodium thiosulfate and salicylic acid in MICEL A® base.†

TINVER—the likable lotion for tinea versicolor—is clinically effective, cosmetically acceptable, and easy to apply. It produces rapid, visible improvement without the objectionable features of oily pastes and odorous solutions. Patient acceptability encourages continued therapy without interruption. TINVER is



practical and economical for long-term therapy.

Indications: For topical use in the treatment of tinea versicolor.

Precautions: If signs of irritation or sensitivity develop, discontinue use. Do not use on or about the eyes.

Dosage and Administration: Thoroughly wash, rinse, and dry the affected area before applying medication. Apply a thin film of the lotion twice a day, or as directed. Although diagnostic evidence of the tinea versicolor may disappear in a few days, it is advisable to continue treatment for a much longer period. Clothing should be boiled to prevent reinfection.

Supply: 5 oz. polyethylene squeeze bottle.

*McClarín, W. M., and Knox, J. M.: *Cutis* 3:619 (June) 1967.

†The MICEL A® base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.

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Sodium thiosulfate USP 25%, salicylic acid USP 1%, isopropyl alcohol NF 10%, and propylene glycol USP, in a MICEL A base of menthol USP, disodium edetate, colloidal alumina, and purified water USP.



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(iodochlorhydroxyquin and hydrocortisone)

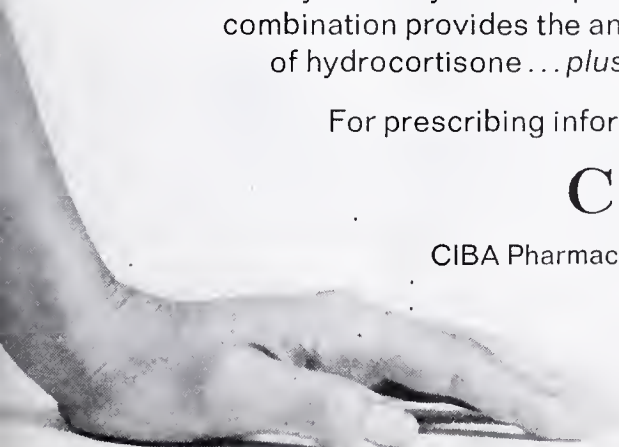
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anti-inflammatory...antipruritic**

Today's "mini" styles and maximum skin exposure lend urgency to your need for effective dermatologic preparations. Of these, plain topical steroids enjoy wide use. But certain common skin disorders—those of fungal or bacterial origin, and skin lesions with secondary infections—require more comprehensive therapy. In fact, plain topical steroids are contraindicated as sole therapy in these cases. That's why so many doctors prescribe Vioform-Hydrocortisone. This combination provides the anti-inflammatory and antipruritic benefits of hydrocortisone... *plus* antibacterial and antifungal actions.

For prescribing information, please see following page.

C I B A

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Indications: Most acute and chronic skin disorders (consult product literature).

Contraindications: Should not be used in the eye, or topically in the presence of tuberculosis, vaccinia, varicella, or other viral skin conditions.

Precautions: May prove irritating to sensitized skin in rare cases. If this occurs, discontinue therapy. May stain. If used under occlusive dressings or for a prolonged period, watch for signs of pituitary-adrenal axis suppression. May interfere with thyroid function tests. Wait at least one month after discontinuance of therapy before performing these tests. The ferric chloride test for phenylketonuria (PKU) can yield a false positive result if Vioform is present in the diaper or urine.

Adverse Reactions: Rare: local burning, irritation, itching. May cause striae at site of application when used for long periods in intertriginous areas.

Dosage: Apply a small amount to affected areas 3 or 4 times daily.

Supplied: *Cream*, 3% iodochlorhydroxyquin and 1% hydrocortisone in a water-washable base containing stearyl alcohol, spermaceti, petrolatum, sodium lauryl sulfate, and glycerin in water; tubes of 5 and 20 Gm. *Ointment*, 3% iodochlorhydroxyquin and 1% hydrocortisone in a petrolatum base; tubes of 5 and 20 Gm. *Lotion*, 3% iodochlorhydroxyquin and 1% hydrocortisone in a water-washable base containing stearic acid, cetyl alcohol, lanolin, propylene glycol, sorbitan trioleate, polysorbate 60, triethanolamine, methylparaben, propylparaben, and perfume Flora in water; plastic squeeze bottles of 15 ml.

Economical Forms for Less Severe

Dermatoses: *Mild Cream*, 3% iodochlorhydroxyquin and 0.5% hydrocortisone in a water-washable base containing stearyl alcohol, spermaceti, petrolatum, sodium lauryl sulfate, and glycerin in water; tubes of ½ and 1 ounce. *Mild Ointment*, 3% iodochlorhydroxyquin and 0.5% hydrocortisone in a petrolatum base; tubes of ½ and 1 ounce.

2/3941MB

C I B A

CIBA Pharmaceutical Company, Summit, N.J.

Notes and News continued from 408

We dutifully attended the Monday luncheon sessions with our Visiting Professor of Pediatrics, U. of Minnesota's **John Anderson**, whose talks covered such esoteric subjects as "Inappropriate ADH Syndrome," "The Genetic Aspect of Jaundice," "Neonatal Enzyme Disorders," "Exudative Enteropathy," etc. Looking remarkably like Ronald Colman, with the same sandy hair and mustache, John apologized, "As you probably have surmised by now, my basic orientation to medicine is biochemical..." and never was one more correct in his surmise for his lectures consisted of formulas followed by yet more formulas. A few listened attentively and seemed to understand, but most seemed to succumb to the heavy lunches, the noonday heat, the construction din, and the academic nature of the lectures. We did, however, retain a few clinical pearls including the "Blue Diaper Syndrome," though we may never encounter it in our short life spans.

Leonard Schuman of the University of Minnesota School of Public Health lectured at Kuakini. Leonard feels the inverse of the old aphorism, or "Locking the barn door before the horse is stolen" is true. Physicians are too often concerned with the problem of motivating lung cancer patients to discontinue smoking when they should be encouraging their healthy patients to stop smoking. The practicing physician will find that over half (51.0%) of his male patients and one-third (33.2%) of his female patients over 17 years old are regular cigarette smokers. In 1965, of the 1,828,136 deaths from all causes, 866,340 (45%) were from diseases associated with tobacco use. In a recent forum of the American College of Chest Physicians and the U.S. Public Health Service, it was concluded that the elimination of cigarette smoking was the single most important health measure available today for the prevention of disease and premature deaths in the U.S. The Forum also recommended that physicians should inquire into every patient's smoking habits, inform each patient of the risks of continued smoking and the benefits of cessation, and advise him strongly against smoking. The screening procedures for all patients over 40 without manifest disease related to smoking should include serum cholesterol, postprandial blood sugar, and uric acid levels, and an EKG.

NEWS

Manuscript Award for 1970

The Obstetrics and Gynecology Specialty Group of the International College of Surgeons has announced an award to be given the author of a manuscript submitted by interns, residents, or graduate students in the field of obstetrics or gynecology. Contestants must hold an M.D. from an accredited college of medicine. Manuscripts must be original, limited to 5,000 words, and submitted in triplicate under an assumed name accompanied by a sealed envelope containing a card bearing the assumed name of the author, the title of the manuscript, and the true name of the author with his degrees, titles, and address.

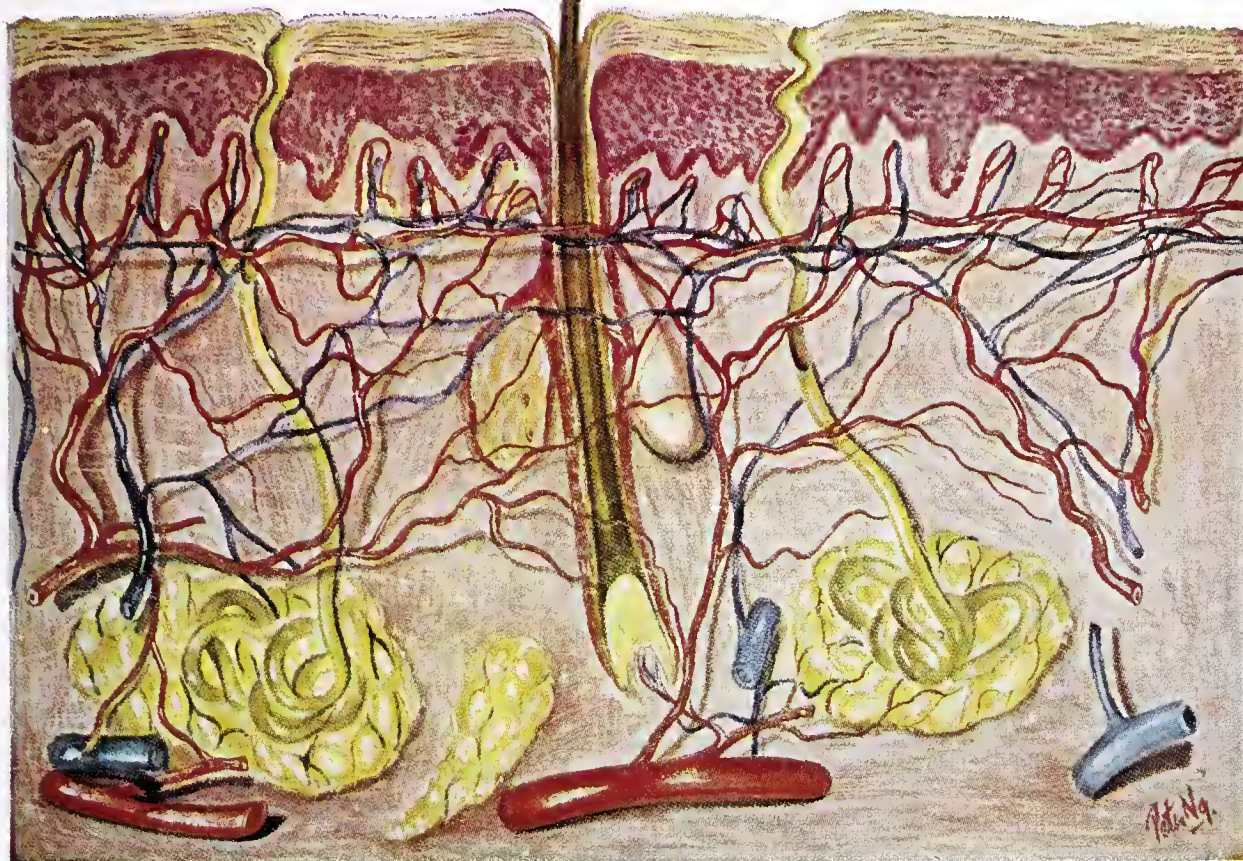
Manuscripts must be submitted to Dr. Eduard Eichner, Chairman of the Prize Committee, 10605 Chester Ave., Cleveland, Ohio 44106, before January 15, 1970. The award will be an invitation to present the winning paper at a meeting in Paris, including a round-trip ticket, hotel expenses, and \$10.00 per diem.

AMA Meeting

The magnetism and the grandeur that characterizes New York City will provide a superb setting for AMA's 118th Annual Convention in July. Plan to attend now and look forward to five memorable and stimulating convention days in a city of unlimited excitement. The complete scientific program, plus forms for advance registration and hotel accommodations, will be featured in JAMA, May 26, 1969. ■

HAWAII MEDICAL JOURNAL

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip.

Complete literature available on request from Professional Services Dept. PML.

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proton, chlorthalidone, can cause side effects. And it's contraindicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

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chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypoten-

sion, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

Average Dosage: 50 or 100 mg. with breakfast daily or 100 mg. every other day.

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In Memoriam continued from 392

where he practiced until 1933 when he settled permanently in Japan and opened the Hasegawa Hospital in Onijiku-machi, Chiba.

During his years in the Islands, Dr. Hasegawa was prominent in Japanese medical circles and as a leader in community affairs. He served as president of the Japanese Medical Association and was a member of the Honolulu Medical Society and of the Hawaii Medical Association.

Dr. Hasegawa died in Chiba in 1965 at the age of 89.

Hawaii Medical Ass'n continued from 400

ual, the physicians will be well represented. It was suggested that perhaps the President-Elect of the HMA be appointed each year.

ACTION:

It was voted that the President-Elect of the HMA be our nominee to the Executive Committee of the RMP each year.

It was voted that the HMA President appoint three additional members to the Regional Advisory Group with the approval of the Council.

FISCAL MATTERS

Request for \$50 contribution: A letter from Mr. H. Tom Thorson, Executive Secretary of the Honolulu

County Medical Society, inviting the HMA to participate in the Annual Medical Assistants' Seminar and Awards Program by providing a \$50.00 contribution for the purchase of a gift certificate award. It was pointed out that the Council appropriated funds for the last Medical Assistants' Seminar.

ACTION:

It was voted to contribute \$50 to the Medical Assistants' Seminar and Awards Program.

Woman's Auxiliary Request: A letter dated March 25, 1969, was received from the President of the Woman's Auxiliary to the HMA requesting that the Council consider raising the amount of their allotment from \$5.00 per doctor to \$10.00.

The Woman's Auxiliary members present asked to change the amount of their request. Instead of requesting \$10.00, they suggested that \$8.00 be allocated and that printing and secretarial services be made available to them without charge.

There was considerable discussion on the matter and because of the Woman's Auxiliary's surplus in their treasury and because of the HMA's deficit, it was felt that this request could not be granted to the Woman's Auxiliary.

ACTION:

It was voted that the HMA not increase its present contribution to the Woman's Auxiliary to the HMA.

Treasurer's Report: The Treasurer's Report was considered and the budget was discussed item by item. After considerable discussion, it was decided to defer action on the report.

ACTION:

It was voted that a correct budget be pre-

continued page 418

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pared and presented to the Council at its next meeting to be scheduled in May.

AMA INVITATION

It was reported that an invitation was submitted to the AMA to hold its 1975 Clinical Convention in Honolulu. A reply from the AMA indicated that this invitation will be considered along with others when the Board of Trustee next meets to review requests.

MAUI REQUEST

The President of the Maui County Medical Society requested that two items be placed on the Council Agenda: (1) Resolution adopted by the Council re the establishment of a common examining board for both MD's and osteopaths. (2) Failure of the Legislative Committee to support the request for a local Board of Trustees which would constitute the governing body of the Maui Hospital.

It was pointed out by the Maui Councillor that Maui physicians are quite concerned about the fact that the Medical Practice Act Committee and the Legislative Committee did not act according to the Council mandate. He was advised that the Medical Practice Act Committee has been having meetings with the osteopaths and that the Legislative Committee did not introduce a bill re this matter because it did not think this was the proper time. It did not want to introduce a bill on a unilateral basis, and there was no law which could be followed. It was further reported that the Medical Practice Act Committee has met several times, it has brought this matter before the Legislative Committee, and they now plan to have the Attorney General work with both the physicians and osteopaths.

The Chairman of the Legislative Committee informed the Council that the Committee did not comply with

Maui County's request because the bills introduced by the Department of Health will, if enacted, complete the transfer of the county hospitals to the State; they do not transfer the governing bodies of the hospitals to the State since this has already been done by Act 97 of the Third State Legislature in 1965. The purpose of the above bills is to transfer the real and personal properties, the administration, and the employees of the Act 97 hospitals to the State. If this is not done, the Director of the Department of Health, as the final authority for the governing of Act 97 hospitals, will be able to act only through the office of the mayor of each county, leading to unavoidable delay in requests by the medical staffs and employees of these hospitals for policy decisions. Killing the bills will not enable the county hospitals to have its own local Board of Trustees. This can only be done if Act 97 of the Third State Legislature is repealed. There has been no bill introduced in the Legislature to do this. Another reason why the Legislative Committee voted not to take a stand on the bills at issue is the fact that the room rate schedules of the Act 97 hospitals were far below the actual costs before the Department of Health took steps to raise the rates to more realistic levels. Until the rate adjustment to cover the cost of operating the hospitals is accomplished, the State will continue to subsidize the insurance companies who write the medical insurance for patients who are admitted to these hospitals and the plantations who pay for the hospitalization of their employees. Still another reason is that the Legislative Committee did not know the feeling of the other county medical societies.

REPORT ON FAMILY LIFE AND SEX EDUCATION

The report and its recommendation were circulated to the Council for review and comment. No discussion was had.

ACTION:

It was voted to accept the report as circulated.
continued page 422

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Before prescribing, see complete prescribing information in SK&F literature or *PDR*.

Contraindications: Hyperexcitability, undue restlessness, hyperthyroidism, porphyria; in patients on MAO inhibitors.

Precautions: Use with caution in patients hypersensitive to sympathomimetics or barbiturates and in coronary or cardiovascular disease or severe hypertension. Excessive use of the amphetamines by unstable individuals may result in a psychological dependence. Rarely, symptoms of toxic psychosis (hallucinations, confusion, panic states, etc.) may occur with amphetamines, usually after prolonged high dosage. In these instances, withdraw the medication. Use cautiously in pregnant patients, especially in the first trimester.

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codeine phosphate, 10 mg. (warning: may be habit-forming); phenylephrine hydrochloride, 10 mg.; chlorpheniramine maleate, 2 mg.; glyceryl guaiacolate, 100 mg.; chloroform, 13.5 mg.; l-menthol, 1 mg.; alcohol 5%.

Use with caution in patients with severe hypertension, diabetes mellitus, hyperthyroidism or urinary retention. Caution ambulatory patients that drowsiness may result. Continuous dosage over an extended period is contraindicated, since codeine phosphate may cause addiction.

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REQUEST FOR ENDORSEMENT

A letter was received from the President of the Health and Hospital Planning Council of Honolulu advising that its Board of Trustees, after thorough review of the alternatives confronting the agency, have by a major consensus indicated their desire to continue as a health facility and service planning agency. It was pointed out in this letter that the planning activity will be similar in scope and function to that performed from June 1, 1963, through June 30, 1968, by its predecessor organization, the Health Facilities Planning Council of Hawaii. The letter requested endorsement by the HMA and asked for HMA support in carrying out what the Planning Council believes is a vitally needed health facility planning function.

ACTION:

It was voted to endorse the Health and Hospital Planning Council of Honolulu.

SECRETARY'S REPORT

The report was circulated to the Council.

ACTION:

It was voted to accept the report and place it on file.

It was also voted that the Secretary, at the Council's next meeting, submit some names as tentative meeting places for the projected annual meetings noted in his report.

OCHAMPUS

Execution of Supplemental Contract Agreement: It was pointed out that HMA has not signed this supplemental contract agreement because of the rate charged for processing claims.

ACTION:

It was voted that this contract be placed on file and that further investigation be conducted to attempt to see if this rate is fair and equitable.

Request for HMSA reimbursement: The correspondence exchanged among HMSA, OCHAMPUS, and HMA was reviewed. HMSA's letter noted that certain HMA expenses were questioned by the Department of Health, Education and Welfare Audit Agency and were disallowed. It was noted by HMSA that since they have paid to the HMA the amount of \$2,274.57 for expenses incurred, they are requesting a reimbursement of \$809.57 which represents the amount of disallowance by OCHAMPUS. Legal Counsel, Mr. V. Thomas Rice, was asked to comment. He said he presumed that the government regulation referred to prohibits reimbursement for the item of \$48 for alcoholic beverages.

ACTION:

It was voted that HMA pay the \$48 in question and contest the balance of the disallowance.

It was suggested that a letter be written to HMSA re Council decision.

AD HOC SEARCH COMMITTEE REPORT

The Council then went into executive session and the Ad Hoc Search Committee report was discussed. Some of the aspects of the plan were modified in such a way as to delineate the responsibilities of the Director of the Department of Public Affairs.

ACTION:

It was voted to approve the proposal as revised.

The meeting adjourned at 1:30 A.M.

R. VARIAN SLOAN, M.D.
Secretary

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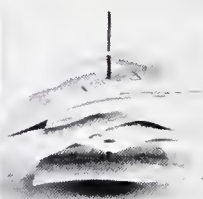
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HAWAII MEDICAL JOURNAL

July-August, 1969

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Caution: As with other antibiotic preparations, prolonged use may result in overgrowth of nonsusceptible organisms and/or fungi. Appropriate measures should be taken if this occurs. Articles in the current medical literature indicate an increase in the prevalence of persons allergic to neomycin. The possibility of such a reaction should be borne in mind.

Contraindications: This product is contraindicated in those individuals who have shown hypersensitivity to any of its components.

Supplied: Tubes of 1 oz., ½ oz. with applicator tip, and ⅛ oz. with ophthalmic tip. Complete literature available on request from Professional Services Dept. PML.

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■ for fever blisters and canker
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Lactinex contains both *Lactobacillus acidophilus* and *L. bulgaricus* in a standardized viable culture, with the naturally occurring metabolic products produced by these organisms.

Lactinex has been shown to be useful in the treatment of gastrointestinal disturbances, and for relieving the painful oral lesions of fever blisters and canker sores of herpetic origin.^{1,2,3,4,5,6,7,8}

No untoward side effects have been reported to date.

Literature on indications and dosage available on request.

HYNSON, WESTCOTT & DUNNING, INC.



Baltimore, Maryland 21201

(LX-D5)

LX
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References:

(1) Siver, R. H.: CMD, 21:109, September 1954. (2) Frykman, H. H.: Minn. Med., 38:19-27, January 1955. (3) McGivney, J.: Tex. State Jour. Med., 51:16-18, January 1955. (4) Quehl, T. M.: Jour. of Florida Acad. Gen. Prac., 15:15-16, October 1965. (5) Weekes, D. J.: N.Y. State Jour. Med., 58:2672-2673, August 1958. (6) Weekes, D. J.: EENT Digest, 25:47-59, December 1963. (7) Abbott, P. L.: Jour. Oral Surg., Anes., & Hosp. Dental Serv., 310-312, July 1961. (8) Rapoport, L. and Levine, W. I.: Oral Surg., Oral Med. & Oral Path., 20:591-593, November 1965.

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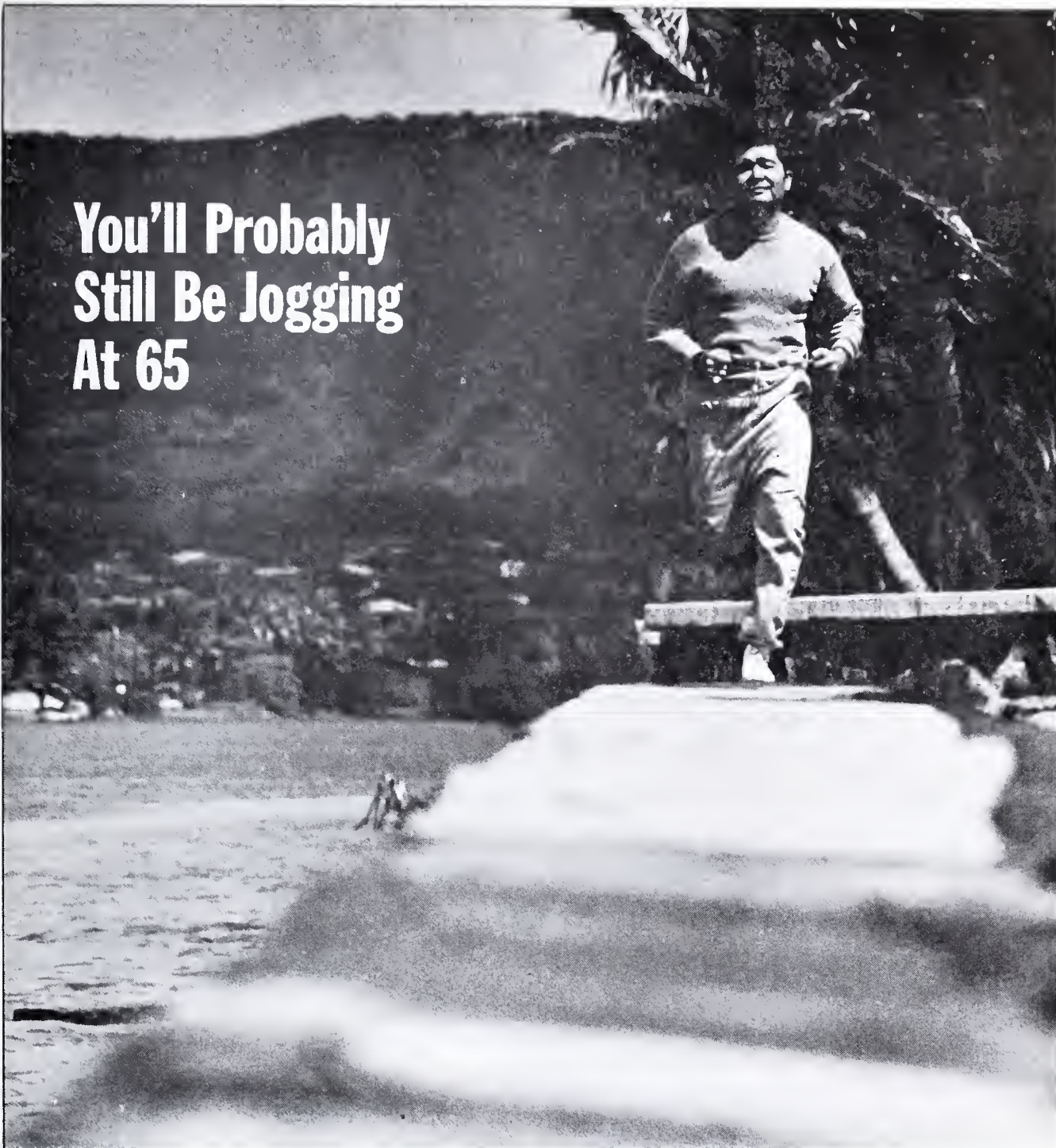
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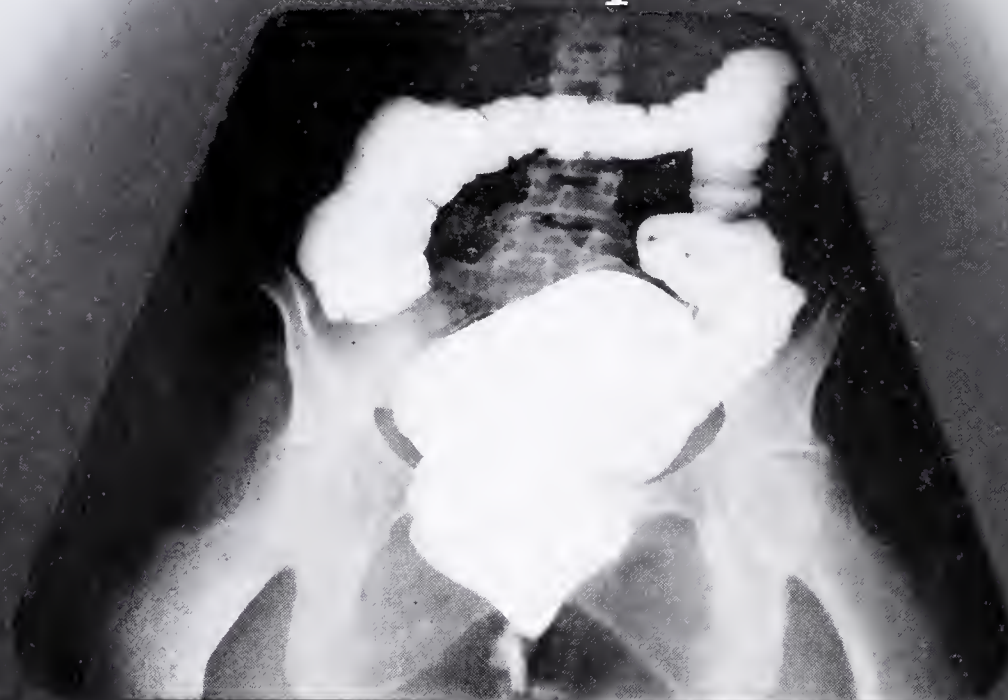
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*X-ray visualization following barium enema.
Patient prepared with single dose of X-PREP
Liquid—2½ oz. Note absence of fecal retention.
Courtesy of Statman, A. J.: An Effective Single-Dose
Evacuant, J. M. Soc. New Jersey 63:95 (March) 1966.*

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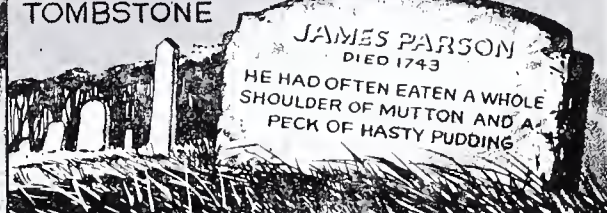
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OVERWEIGHT ROMAN HORSEMEN WERE MADE TO FORFEIT THEIR MOUNTS AND BECOME FOOT SOLDIERS!



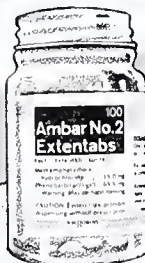
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TOMBSTONE



SHAKESPEARE

WAS AWARE OF THE
DANGERS OF OBESITY
HE WROTE...

*Make less thy body hence
and more thy grace,
leave gormandizing;
know thy grave doth
gape for thee wider
than for other men.*



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**AMBAR
EXTENTABS**

IS APPROXIMATELY ONE
HALF THAT OF OTHER LEAD-
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**AN IMPORTANT FACTOR
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methamphetamine HCl 15 mg.,
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One Ambar Extentab before breakfast can help control most patients' appetite for up to 12 hours. Methamphetamine, the appetite suppressant, gently elevates mood and helps overcome dieting frustrations. Phenobarbital, the sedative in Ambar, controls irritability and anxiety... helps maintain a state of mental calm and equanimity. Both work together to ease the tensions that erode the willpower during periods of dieting. Also available: Ambar #1 Extentabs®—methamphetamine hydrochloride 10 mg., phenobarbital 64.8 mg. (1 gr.) (Warning: may be habit forming).

BRIEF SUMMARY/Indications: Ambar suppresses appetite and helps offset emotional reactions to dieting. **Contraindications:** Hypersensitivity to barbiturates or sympathomimetics; patients with advanced renal or hepatic disease. **Precautions:** Administer with caution in the presence of cardiovascular disease or hypertension. **Side Effects:** Nervousness or excitement occasionally noted, but usually infrequent at recommended dosages. Slight drowsiness has been reported rarely. See package insert for further details.

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Indications: Infections susceptible to oral penicillin G: prophylaxis and treatment of streptococcal infections; treatment of pneumococcal, gonococcal, and susceptible staphylococcal infections; prophylaxis of rheumatic fever in patients with a previous history of the disease.

Contraindications: Infections caused by nonsusceptible organisms; history of penicillin sensitivity.

Warnings: Acute anaphylaxis (may prove fatal unless promptly controlled) is rare but more frequent in patients with previous penicillin sensitivity, bronchial asthma or other allergies. Resuscitative (epinephrine, aminophylline, pressor amines) and supportive (antihistamines, methylprednisolone sodium succinate) drugs should be readily available. Other rare hypersensitivity reactions include nephropathy, hemolytic anemia, leucopenia and thrombocytopenia.

In suspected hypersensitivity, evaluation of renal and hematopoietic systems is recommended.

Precautions: In suspected staphylococcal infections, perform proper laboratory studies including sensitivity tests. If overgrowth of nonsusceptible organisms occurs (constant observation is essential), discontinue penicillin and take appropriate measures. Whenever allergic reactions occur, withdraw penicillin unless condition being treated is considered life threatening and amenable only to penicillin. Penicillin may delay or prevent appearance of primary syphilitic lesions. Gonorrhea patients suspected of concurrent syphilis should be tested serologically for at least 3 months. When lesions of primary syphilis are suspected, dark-field examination should precede use of penicillin. Treat beta-hemolytic streptococcal infections with full therapeutic dosage for at least 10 days to prevent rheumatic fever or glomerulonephritis. In staphylococcal infections, perform surgery as indicated.

Adverse Reactions: (Penicillin has significant index of sensitization); Skin rashes, ranging from maculopapular eruptions to exfoliative dermatitis; urticaria; serum sickness-like reactions, including chills, fever, edema, arthralgia and prostration. Severe and often fatal anaphylaxis has been reported (see "Warnings").

Composition: Tablets—125 mg. (200,000 units), 250 mg. (400,000 units), 500 mg. (800,000 units); Liquid—125 mg. (200,000 units) and 250 mg. (400,000 units) per 5 cc.

Wyeth Laboratories Philadelphia, Pa.

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(potassium phenoxymethyl penicillin)



the thousandth teaspoonful

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the thousandth dose of
this antacid as effective
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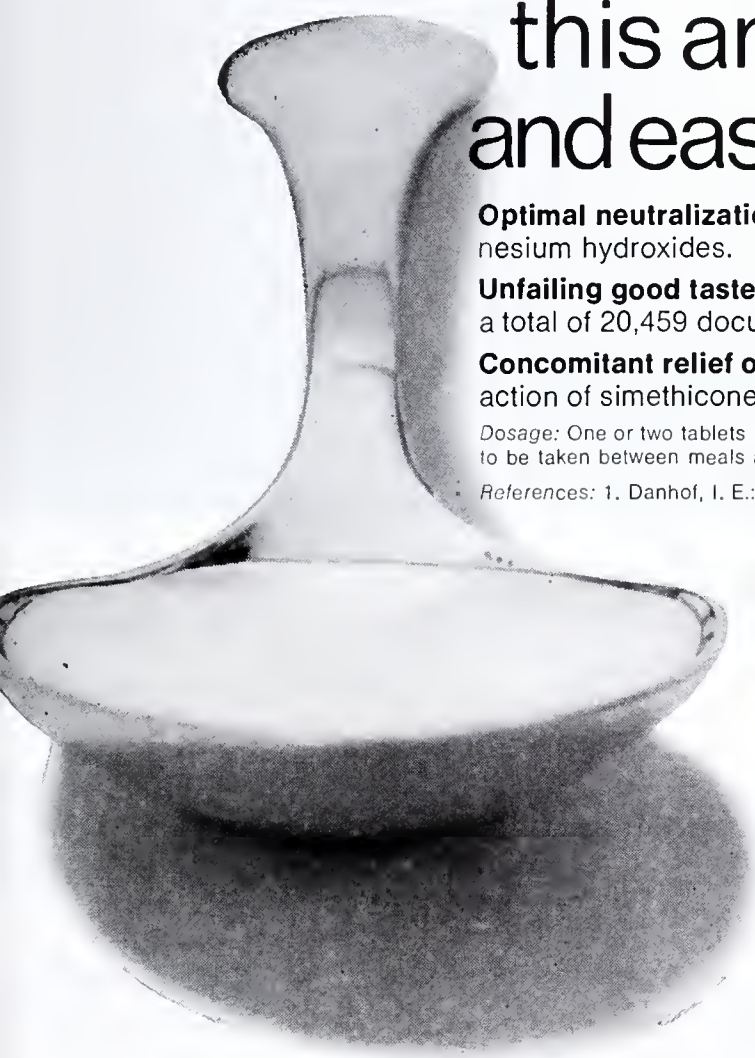
Dosage: One or two tablets (well chewed or allowed to dissolve in the mouth); one or two teaspoonfuls to be taken between meals and at bedtime, or as directed by physician.

References: 1. Danhof, I. E.: Report on file. 2. Hoon, J. R.: Arch. Surg. 93:467 (Sept.) 1966.

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aluminum and magnesium hydroxides *plus* simethicone

Stuart

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Steroid-nutritional compound

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Conjugated estrogens-equine (PREMARIN®)	0.25 mg.	0.25 mg.
Methyltestosterone	2.5 mg.	2.5 mg.
Methamphetamine HCl	1.0 mg.	1.0 mg.
Cyanocobalamin	2.5 mcg.	1.5 mcg.
Intrinsic factor concentrate	8.0 mg.	—
Thiamine HCl	—	5.0 mg.
Thiamine mononitrate	10.0 mg.	—
Riboflavin	5.0 mg.	—
Niacinamide	50.0 mg.	—
Pyridoxine HCl	3.0 mg.	—
Calcium pantothenate	20.0 mg.	—
Ferrous sulfate exsic.	30.0 mg.	—
Ascorbic acid	100.0 mg.	—

Contains 15%
alcohol†
† Some Loss
Unavoidable.

Contraindication: Carcinoma of the prostate, due to methyltestosterone component.

Warning: Some patients with pernicious anemia may not respond to treatment with the Tablets or Capsules, nor is cessation of response predictable. Periodic examinations and laboratory studies of pernicious anemia patients are essential and recommended.

Side Effects: In addition to withdrawal bleeding, breast tenderness or hirsutism may occur.

Suggested Dosages: *Male and female*—1 Tablet or Capsule, or 3 teaspoonfuls Liquid, daily or as required.

In the female: To avoid continuous stimulation of breast and uterus, cyclic therapy is recommended (3 week regimen with 1 week rest period—Withdrawal bleeding may occur during this 1 week rest period).

In the male: A careful check should be made on the status of the prostate gland when therapy is given for protracted intervals.

Supplied: No. 752—MEDIATRIC Tablets, in bottles of 100 and 1,000.
No. 252—MEDIATRIC Capsules, in bottles of 30, 100, and 1,000.
No. 910—MEDIATRIC Liquid, in bottles of 16 fluidounces.



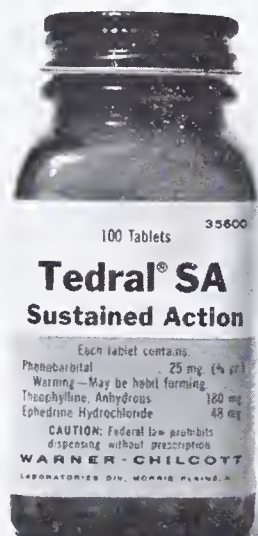
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action helps them live with
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easily remembered B.I.D. dosage.**

Turn page for prescribing information.

The air that comes in tablets

Tedral[®] SA Sustained Action

Each double-layered, uncoated, coral/mottled white tablet of Tedral SA contains 180 mg. anhydrous theophylline (90 mg. in the immediate release layer and 90 mg. in the sustained release layer); 48 mg. ephedrine hydrochloride (16 mg. in the immediate release layer and 32 mg. in the sustained release layer); 25 mg. phenobarbital.

Tedral[®]

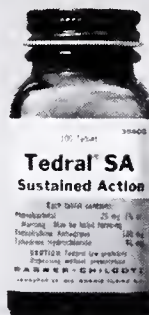
Each white uncoated, scored tablet contains 130 mg. theophylline, 24 mg. ephedrine hydrochloride, and 8 mg. phenobarbital.

Tedral[®] Expectorant

Each white tablet contains 130 mg. theophylline, 24 mg. ephedrine hydrochloride, 8 mg. phenobarbital, and 100 mg. glyceryl guaiacolate.

Tedral-25[®]

Each salmon-pink uncoated, scored tablet contains 130 mg. theophylline, 24 mg. ephedrine hydrochloride, and 25 mg. butabarbital.



Indications: Tedral, Tedral SA, Tedral-25, and Tedral Expectorant are indicated for the symptomatic relief of bronchial asthma, asthmatic bronchitis, and bronchospastic disorders. They may also be used prophylactically to abort or minimize asthmatic attacks and are of value in managing occasional, seasonal, or perennial asthma.

Tedral SA (Sustained Action) offers the convenience of b.i.d. dosage.

Tedral-25 is indicated when there is excessive nervousness, apprehension or sensitivity to ephedrine.

Tedral Expectorant is indicated only when both relaxation of bronchospasm and expectoration are desired.

These Tedral formulations are adjuncts in the total management of the asthmatic patient. Acute or severe asthmatic attacks may necessitate supplemental therapy with other drugs by inhalation or other parenteral routes.

Contraindications: Sensitivity to any of the ingredients; porphyria.

Warning: Phenobarbital or butabarbital may be habit-forming.

Precautions: Use with caution in the presence of cardiovascular disease, severe hypertension, hyperthyroidism, prostatic hypertrophy, or glaucoma.

Adverse Reactions: Mild epigastric distress, palpitation, tremulousness, insomnia, difficulty of micturition, and CNS stimulation have been reported.

Dosage: Tedral. Adults (average prophylactic or therapeutic dosage)—one or two tablets every 4 hours. With the one-tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. Children (over 60 lb.)—one-half the adult dose.

Tedral SA. Adults (average prophylactic or therapeutic dosage)—one tablet on arising and one tablet 12 hours later. Tablets should not be chewed. Dosage in children under 12 is not recommended because usage has not been established.

Tedral-25. Adults (average prophylactic or therapeutic dosage)—one or two tablets every 4 hours. With the one-tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. Children (over 60 lb.)—one-half the adult dose.

Tedral Expectorant. Adults: One or two tablets q.i.d. With the one tablet dose, an additional tablet may be taken at onset of symptoms, but dosage should not exceed two tablets in any 4-hour period. Dosage in children under 12 is not recommended because usage has not been established.

Supplied: Tedral. Bottles of 24, 100 and 1000 tablets.

Tedral SA. Bottles of 100 and 1000 tablets. Tedral SA is available on prescription only.

Tedral-25. Bottles of 100 tablets. Tedral-25 is available on prescription only.

Tedral Expectorant Tablets. Bottles of 100. Tedral Expectorant is available on prescription only.

Full information is available on request.

T-GP-91-20



WARNER-CHILCOTT
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A specific solution for tinea versicolor

Although tinea versicolor is not a serious disease it is chronic and recurrent and specific treatment is cosmetically important. "Of the wide variety of compounds recommended for the treatment of tinea versicolor, sodium thiosulfate still remains the standard."^{*} However, when sodium thiosulfate is administered alone it decomposes rapidly and produces an offensive odor. These disadvantages have been largely eliminated by the development of TINVER Lotion, which contains sodium thiosulfate and salicylic acid in MICEL A[®] base.[†]

TINVER—the likable lotion for tinea versicolor—is clinically effective, cosmetically acceptable, and easy to apply. It produces rapid, visible improvement without the objectionable features of oily pastes and odorous solutions. Patient acceptability encourages continued therapy without interruption. TINVER is

practical and economical for long-term therapy.

Indications: For topical use in the treatment of tinea versicolor.

Precautions: If signs of irritation or sensitivity develop, discontinue use. Do not use on or about the eyes.

Dosage and Administration: Thoroughly wash, rinse, and dry the affected area before applying medication. Apply a thin film of the lotion twice a day, or as directed. Although diagnostic evidence of the tinea versicolor may disappear in a few days, it is advisable to

continue treatment for a much longer period. Clothing should be boiled to prevent reinfection.

Supply: 5 oz. polyethylene squeeze bottle.

^{*}McClarín, W. M., and Knox, J. M.: *Cutis* 3:619 (June) 1967.

[†]The MICEL A[®] base is a thixotropic gel of colloidal alumina with unique compounding properties. The base dries to an invisible film that holds ingredients on the skin without powdering or flaking.



Tinver[®] Lotion

Sodium thiosulfate USP 25%, salicylic acid USP 1%, isopropyl alcohol NF 10%, and propylene glycol USP, in a MICEL A base of menthol USP, disodium edetate, colloidal alumina, and purified water USP.



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chlorthalidone



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**the way from one daily tablet to the next
help control edema and hypertension**

prolonged action usually provides smooth, sustained diuretic effectiveness; real one-a-day dosage, right from the start; convenience and economy.

hydrochlorothiazide, chlorthalidone, can cause side effects. And it's contraindicated in hypersensitivity to the drug and severe renal and hepatic diseases.

Check the prescribing information. It's summarized on the next page.

Geigy



A little Hygroton® can work a long diuretic day

chlorthalidone

Indications: Hypertension and many types of edema involving retention of salt and water.

Contraindications: Hypersensitivity and most cases of severe renal or hepatic diseases.

Warning: With the administration of enteric-coated potassium supplements, which should be used only when adequate dietary supplementation is not practical, the possibility of small-bowel lesions (obstruction, hemorrhage, and perforation) should be kept in mind. Surgery for these lesions has been required frequently and deaths have occurred. Discontinue enteric-coated potassium supplements immediately if abdominal pain, distention, nausea, vomiting, or gastrointestinal bleeding occur.

Use with caution in pregnant women and nursing mothers since the drug may cross the placental barrier and appear in cord blood and since thiazides may appear in breast milk. The drug may result in fetal or neonatal jaundice, thrombocytopenia, and possibly other adverse reactions which have occurred in the adult. When used in women of childbearing age, balance benefits of drug against possible hazards to fetus.

Precautions: Antihypertensive therapy with this drug should always be initiated cautiously in postsympathectomy patients and in patients receiving ganglionic blocking agents, other potent antihypertensive drugs or curare. Reduce dosage of concomitant antihypertensive agents by at least one-half. Because of the possibility of progression of renal damage, periodic determination of the BUN is indicated. Discontinue if the BUN rises or liver dysfunction is aggravated. Hepatic coma may be precipitated.

Electrolyte imbalance, sodium and/or potassium depletion may occur. If potassium depletion should occur during therapy, the drug should be discontinued and potassium supplements given, provided the patient does not have marked oliguria.

Take special care in cirrhosis or severe ischemic heart disease and in patients receiving corticosteroids, ACTH, or digitalis. Salt restriction is not recommended.

Adverse Reactions: Nausea, gastric irritation, vomiting, anorexia, constipation and cramping, dizziness, weakness, restlessness, hyperglycemia, glycosuria, hyperuricemia, headache, muscle cramps, orthostatic hypoten-

sion, which may be potentiated when chlorthalidone is combined with barbiturates, narcotics or alcohol, aplastic anemia, leukopenia, thrombocytopenia, agranulocytosis, impotence, dysuria, transient myopia, skin rashes, urticaria, purpura, necrotizing angitis, acute gout, and pancreatitis when epigastric pain or unexplained G.I. symptoms develop after prolonged administration. Other reactions reported with this class of compounds include: jaundice, xanthopsia, paresthesia, and photosensitization.

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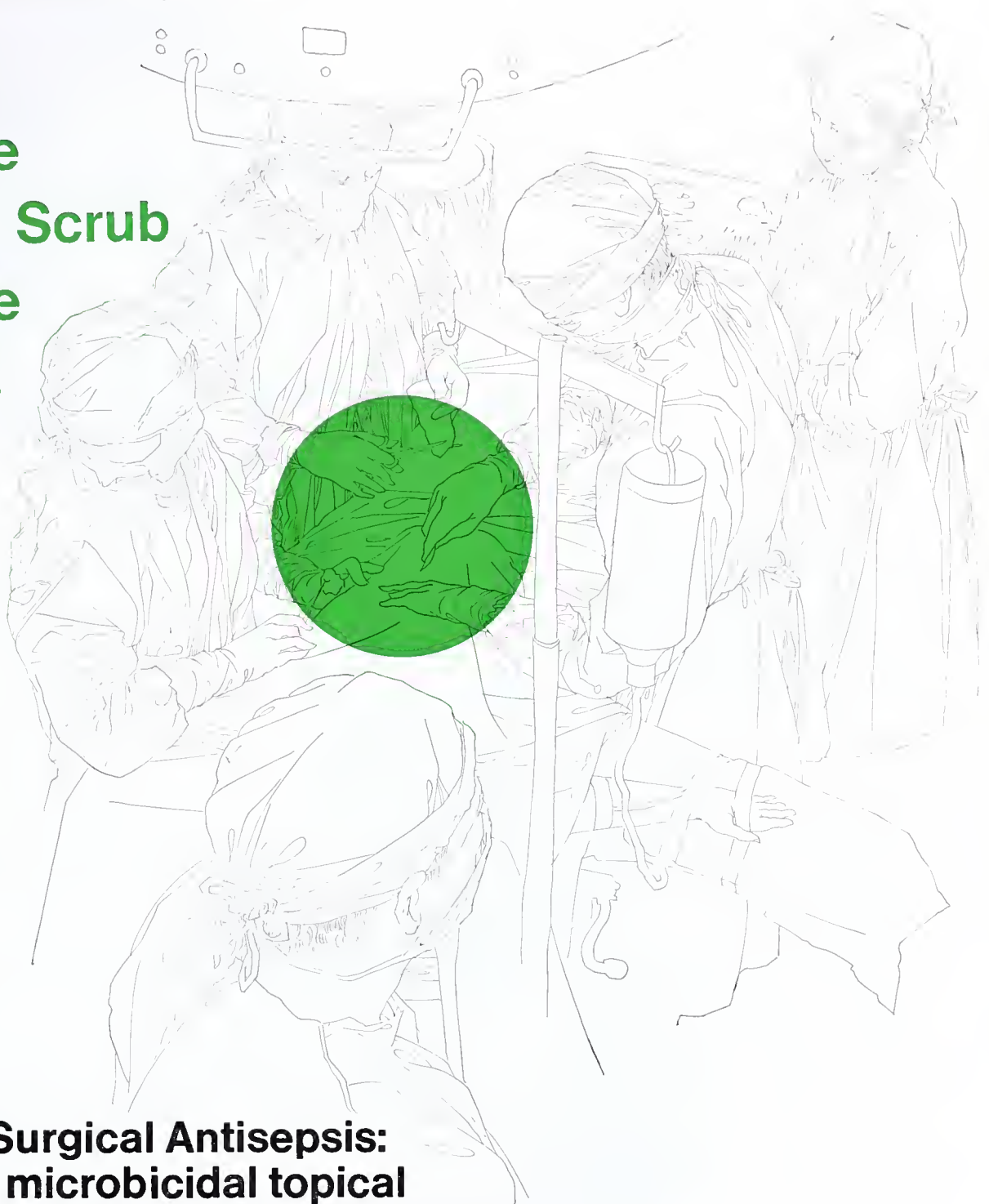


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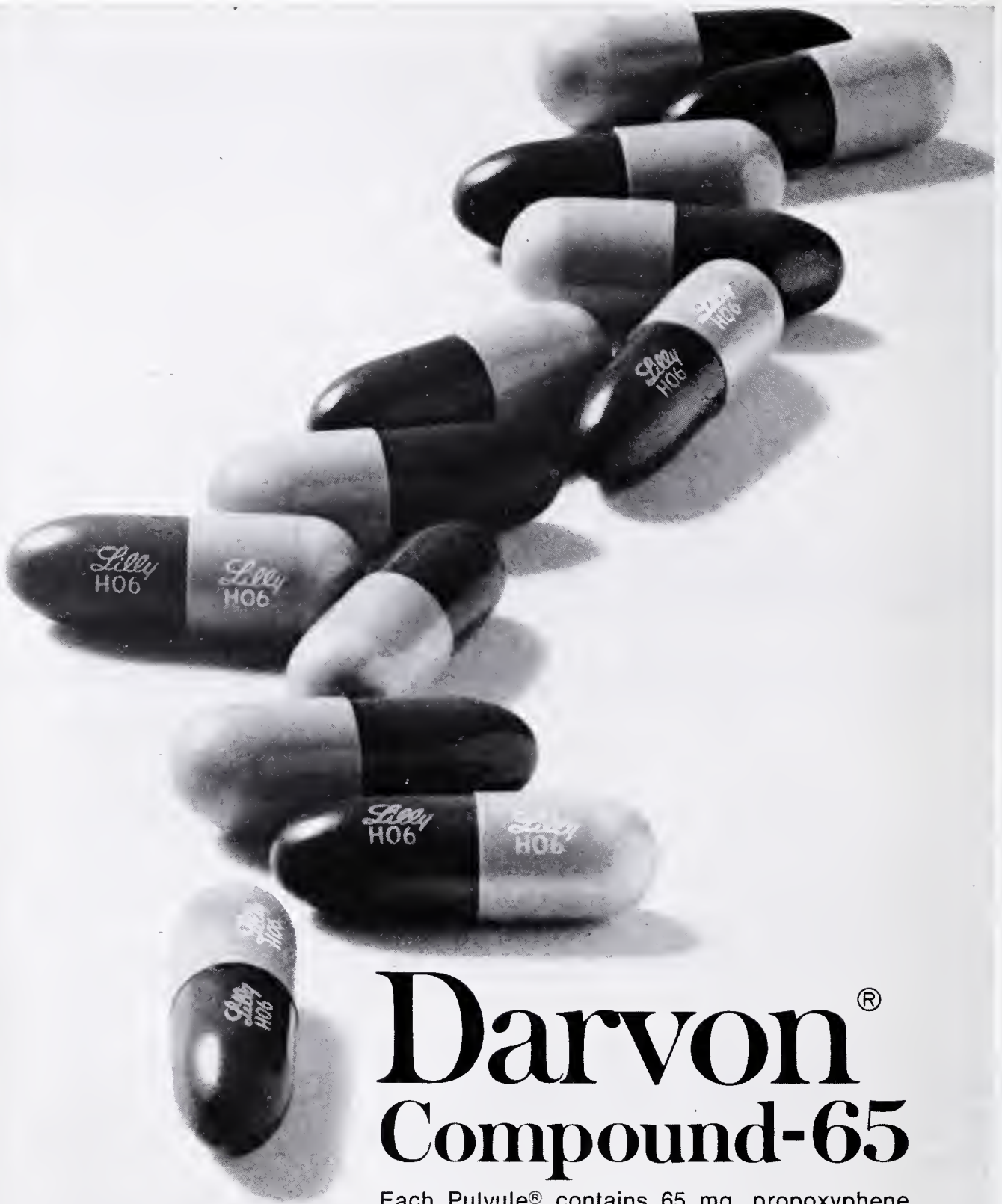
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Presidential Address

Hawaii Medical Association's Concern With Medical Care Costs

ROBERT M. MIYAMOTO, M.D., *Honolulu*

THE PRACTICING physician has been more concerned with the complicated mechanism of the human body than with the cost of treating that mechanism. Some people say doctors are disease oriented, and we are. That is because all our training is directed toward alleviation of the ills of the human body. It seems to me that such orientation is proper.

Practicing physicians, nevertheless, must pay more attention to health costs. A good reason for this is that national attention to generally increased prices is most often directed toward these charges.

While all providers of health care are concerned with rapidly rising costs, physicians now find themselves especially concerned. We are the ones most often blamed, even though most of the increases are due to causes over which we have no control.

There are many reasons why providers of health care to the public are faced with growing burdens and responsibilities. One reason is the increasing U.S. population. An important function of the human body is the reproduction of other individuals of the species. People today are working at the function very enthusiastically. Doctors can't stem the tide, although today they can show patients how to slow down reproduction if they so choose. Increased copulation no longer needs to mean increased population.

Another reason for the growing burden is the constantly increasing demand for health services, and the mounting rate of utilization of those services. In addition there are spectacular scientific advances, costly to finance, costly to utilize.

And there are the many, many burgeoning Federal health programs, each exacting a high price in taxes. The Social Security tax alone is 9.6 per cent this year. And it's going up.

The major shift from private to public funds to pay for health care began in mid-1966 when Medicare went into effect. That year, the total of \$4.5 billion spent by the Nation for its health and medical care accounted for 11 per cent over the amount spent the previous year. As the result of new programs and the expansion of existing programs, the proportion of public expenditures, as related to total expenditures, rose from 25 per cent in '65 to 28 per cent in '66. The major share of this increase was in the Federal sector, which rose from 12 to 16 per cent.

This shift in the burden from private to public funds will be considerably more apparent as the social welfare programs grow and grow. Take hospital care, the largest single slice of the health dollar, about one-third, in fact. In 1966 the Federal Government's share of that slice rose to 19 per cent, compared to 14 per cent in 1965. The consumer's share, conversely, went down from 61 per cent to 57 per cent.

Physicians' services call for the next largest chunk of the health dollar—just about 21 per cent of the total. The Federal share in these payments rose 40 per cent in 1966, compared to 1965. This trend will become even more pronounced as the Government assumes more and more responsibility for the payment for services once paid for by the patient or donated by the physician.

I want to mention one area of health care expenditure which has not yet received a great deal of publicity: that is, nursing home care. The gross

Delivered at the 113th Annual Meeting of the Hawaii Medical Association, May 22, 1969.

amount of private consumer expenditures for nursing home care in 1950 was \$110 million; in 1961 it was \$411 million. In 1966 it was \$811 million. Per capita expenditures during those years were 73 cents, \$2.31, and \$4.16, respectively. The first year such costs were partly covered by Medicare was 1967. In 1966 the total of both public and private expenditures was \$1,502 million, whereas in 1960 it was \$526 million. The 1968 figures are not totaled. You can count on another substantial increase.

From these data, published in the April, 1966, issue of *Social Security Bulletin*, we may infer that the availability of government funds to care for people in nursing homes has decreased the numbers of those who remain at home at no cost to the taxpayer. Expenditures for prepayment and administration went from \$863 million in 1960 to \$1,629 million in 1966. On a per capita basis, this increase was from \$4.78 to \$8.27.

Not all changes in the delivery system of health care have such a dramatic line of demarcation. The increased use of hospital emergency rooms for after-hours visits, not so great here as on the mainland, has been gradual. It nevertheless plays an important part in the over-all increase in costs.

Personal health care expenditures amounted to \$39.1 billion in 1966, an increase of nearly \$4 billion over 1965. It was three and one-half times the total for 1950. On the \$28 billion increase since 1950, 46 per cent can be attributed to increases in medical care prices and 18 per cent to population increase. The remaining portion, 35 per cent, represents the increase resulting from greater utilization of services and the introduction of new medical techniques.

Carlyle said you can prove anything by figures. It is an easy matter to prove that the entrance of government increases the cost. We are not trying to prove that: we already know it. And we know those costs will increase. Most important is how we can find ways to see that every person in the nation attains and maintains physical and mental well-being. What we must do, as we spend ever-increasing sums, is to insure that we get the most for each health dollar spent.

The approaches used for business and industry cannot be applied to health care, either. Profit-sharing incentives could impair the quality of care rendered. Certainly it would cut down the cost of medical care if routine chest x-rays were skipped. But would it decrease the cost if the patient who skipped the x-ray were later found to have TB?

Neither do we want to cut down on costs involved in launching and maintaining important research projects. Research is providing us with new and specialized techniques and medicines.

But I say again that we want to be certain that the money is well spent. Research in 1966 cost \$1,632 million. That was more than double the amount spent in 1960. This does not include the expenditures of drug and medical supply companies, because these are included in the cost of the project.

Hospitals accounted for about a third of each dollar spent for health care in 1966, for some very good reasons. And hospital charges are the fastest-rising element of health care costs. Wages paid to hospital employees are the major factor in the costs of such institutions. More elaborate equipment and increased standards of care have meant an increased demand for the trained manpower and womanpower so vital to the successful operation of our fine hospitals.

In the last 20 years the cost of virtually all services has risen much more rapidly than the cost of consumer goods. Long neglected hospital employees have won merited increases in the last two years, but their pay is still low compared to other labor groups. Although they are achieving what the *New York Times* has called belated justice, nowhere in a hospital will you find highly skilled professional people who receive the wages common in industry. Hawaii's hospital personnel did win raises of 20 per cent and 40 per cent in the last two years. This is about twice the rate of increase in commerce and industry. But these nurses and technicians still earn less than plumbers, painters, or electricians.

You might be able to paint your own house and save money. On occasion you can repair a tap, or tinker with your wiring at considerable risk to your fingers. But if you are in a hospital requiring nursing and blood tests, you can't nurse yourself, let alone run into the laboratory and fiddle with test tubes and centrifuges. No, we do not want to reverse the present trend toward giving hospital experts the going wage in industry.

What then? How can we stem the rising costs of hospital care? We know that hospital construction and staffing are under constant scrutiny and that there is continuing study to develop more efficient utilization. We as physicians can help cut costs by enlisting the cooperation of our patients, to see that they do not remain in hospital a single day longer than necessary. We can back plans for eliminating purchase of duplicate equipment in hospitals that almost jostle each other. We can help by writing complete medical records and keeping them up to date.

What can we do in our own offices? We know that general inflationary cost trends will continue, and we must therefore find ways to increase our productivity. The larger number of personnel in

doctors' offices today has enabled us to see more patients in a given day, but it also has increased the cost of practice.

We hear about economy of scale. Some contend there is a relation between size and efficiency. The economists who dwell upon this, however, are quite willing to admit that they cannot measure quality. Physicians can and do specialize in quality control, and they must be cautioned against giving in to pressures to see more patients than they can handle well. Practicing more medicine cannot take the place of practicing better medicine.

Concerning quality itself, no method has been devised to figure out an acceptable and workable definition. The Hawaii Medical Association has initiated a study in this State. We are not able, however, to make positive statements on the basis of the preliminary survey made by Dr. Sanazaro. There is no doubt, though, that the improvement of medical care, the increase in medical care costs are related.

Still without actually defining quality, we can state from the evidence apparent to our brains and fingertips that there are variations in the quality of medical care received by the people of Hawaii. These variations, however, are minor when compared to the differences in other areas, particularly the large mainland cities with high density slum areas. The Waiānae-Nanakuli and the Kalihi-Palama areas, chosen for demonstration projects because of their low-income populations, cannot be compared with ghettos one finds on the mainland.

The question of doctors' fees inevitably enters any discussion of the cost of medical care. How has the shortage of physicians affected increased fees? There is no doubt but that the emphasis on medical specialists has helped boost fees. One would expect the more highly trained to earn more. And while less than two per cent of today's medical school graduates go into general practice, they too must spend more and more time in keeping up with scientific developments in medicine. Why, today they screen for psychiatrists and even save some from the couch.

Another reason for higher costs of medical practice, and resultant higher fees is the increasing time that physicians must spend upon nonmedical duties. The time today's doctors must spend in managerial responsibilities, supervising nonmedical personnel, fulfilling the Government's demands for filling out forms, and answering other administrative requirements, plus new legal responsibilities, cut into patient care and contributes toward higher costs that continue to develop.

The number of physicians is increasing at a

higher rate than that of the population in general. In 15 years the U.S. population increased 17 per cent while the number of physicians increased 22 per cent. But the greatest increase during the period 1955-65 was in the area of physician-directed services, an increase which has resulted from the use of staff assistance. This naturally caused more dollars to be spent for health care, and a substantial rise in the availability and use of health services, and a continuing and inexorable demand for even more physicians.

But even though the number of physicians continues to increase at a rate higher than the growth of population, shortages will continue. This is despite the creation of new medical schools, expansion of present schools, and revisions in curriculum intended to speed up production of doctors without impairing their education. But we are trying. We *are* trying.

Perhaps we should talk more about the high cost of keeping well. Compare that cost with the cost of illness or disability. Medical treatment now actually reduces loss in wages caused by illness. Many diseases, if incurred only a few years ago, would have taken the patient away from work for years or for life. Today they are treated and the patient returns swiftly to his job and his earnings. Immunization prevents diseases that would be expensive to treat. Drug therapy helps keep many people out of mental institutions. Many who are committed can expect early release. Still more can, and needs to, be done toward preventive care and just plain prevention of death by illness, injury, and neglect.

Why, for instance, doesn't Hawaii fluoridate its water and save millions in dental bills paid by individuals and by government? Lack of such legislation in Hawaii is a sheer disgrace. Take the horrendous toll of deaths and injuries in auto accidents every year. Would better engineering of cars and roads and strict enforcement of laws against speeding and drunkenness reduce the total? Sweden has found this to be true after a crack-down on drunk drivers. Industrial accidents claim 39 lives a day. Many are the result of unsafe working conditions. Fire killed more than 12,000 Americans last year.

What about smoking? No one smokes because it is good for him. Everybody knows that smoking is hazardous to health. Dr. Lester Breslow has said that the elimination of cigarette smoking in the state of California would save more lives than doubling the number of doctors in the Golden State. Yet, expenditures for tobacco in 1966 came to \$8.8 billion. That came to 1.9 per cent of total personal expenditures. And it was spent to promote personal air pollution.

Air pollution in general adds to the increasing

incidence of lung cancer and emphysema. We are fortunate in not yet having this problem in Hilo, but let us wait and see. It's a potential threat.

Intelligent people know that life expectancy goes down when fat accumulates. They know what to do about it. But they continue to eat too much and exercise too little. Even President Kennedy's physical fitness program met almost general apathy.

How can we increase the average American's life expectancy, which is 37th among his counterparts among other civilized nations of the world? Eighteen years ago he was in seventh place. An eminent Harvard scientist says that except for our lazy habits there is no reason why we should not have the same life expectancy as those of other countries whose other habits are much like ours. In Norway, New Zealand, and even in strife torn Israel, a man can expect to live 75 years. Even Russia and her European satellites show a higher life expectancy than the 68.5 year expectancy of the U.S. male.

Obesity is a significant health problem in the United States because it provokes the onset, and increases the severity, of a number of chronic diseases. Our way of life now tends to foster physical inactivity. We ride rather than walk, take the elevator rather than the stairs, and are spectators rather than participants. Overweight is difficult to avoid at present sedentary activity levels. We will have to consciously step up our physical activities or eat Spartan meals all our lives.

What can we as physicians do to help people stop killing themselves because they smoke too

much, drink too much, eat too much, drive too fast, and sleep and exercise too little? We can't deny the people the pleasure of driving, eating, drinking, and smoking themselves to death. More money in the health field won't solve many of these problems. As physicians, however, we can be most effective when we put pressure on getting someone else to do something—toward creating a better health milieu. There are three important ways in which influences can produce results. These are in the fields of environment, habits, and genetics. We do make some effort to produce a healthy environment. If we can develop a nation of sybarites, which we have done, we ought to be able to develop a nation of people willing to change their habits in the interest of longer and more healthy life.

No matter how many miraculous new drugs are discovered; no matter what scientific wonders are presented; no matter how many potentially dangerous conditions are identified—we won't find our life spans increasing much beyond what they are today unless we convince people they need to change their habits. That is one phase of the problem.

The genetics problem? We can look to research to help us. Perhaps, some day, we can keep our defective genes from being passed on to our progeny, thus turning back the trend toward greater numbers of people with inherited disease.

Hopefull, the new order of things and massive injections of public money will alter the environment in which many disadvantaged persons are confined. ■

Ephedrine Combats Pain Caused by Local Anesthetics

PROTRACTED PAIN following minor procedures in which one of the local anesthetics *without* epinephrine was used, or *rebound* pain after the combination of steroid and anesthetic, often responds dramatically to $\frac{3}{8}$ or $\frac{3}{4}$ grain of ephedrine by mouth. The pain is usually pounding and caused by vasodilatation. I have used it successfully for relief of pain following dental procedures or peripheral surgery, and rebound pain. This method does not seem to be widely known or tried, which is the reason for presentation.

H. P. KRAMER, M.D.

*A new formulation extends the usefulness
of an old method of treating burns.*

Treatment of Burns and Pyoderma with 0.5% Silver Nitrate Ointment

KOME KURESA, D.S.M., LANCELOT EVES, D.S.M., and

C. S. JUDD, JR., M.D.,* *Apia, Western Samoa*

● *Silver nitrate ointment, 0.5%, has been employed in place of 0.5% silver nitrate solution in the treatment of burns. It is particularly adapted to outpatient burn cases. Its effectiveness has been apparent also in the treatment of common pyodermas. Its advantages are safety, a wide range of bacteriostatic effectiveness, and inexpensiveness.*

ONE OF THE most valuable contributions to the surgical literature in recent years was an article by Moyer and associates¹ in 1965, describing the treatment of burns with continuous wet dressings of 0.5% silver nitrate solution. Anyone who has used this treatment knows its effectiveness. The only disadvantage is the brown discoloration of skin, dressings, linens, clothing, and containers that come in contact with the solution.

In searching for a safe antiseptic to be used on burns, Moyer and his associates cited the following qualities:

1. It must be nontoxic, if absorbable.
2. It must be soluble in water, saline, or lipid in order that vaporizational heat loss be minimized while antisepsis is being effected.
3. The antiseptic action must be prolonged.
4. It must not kill viable tissue cells in the wound, nor interfere with the proliferation of epidermis or the taking of skin grafts.
5. It should be nonantigenic.
6. Resistant strains of pathogenic organisms should not develop during its use.
7. It should be readily procurable.

They found that silver nitrate solution, 0.5%, fulfilled all these qualities. Its use was directed toward the following burn wound organisms: *Staphylococcus aureus*, *Pseudomonas aeruginosa* (pyocyanea), beta hemolytic streptococci, and *Escherichia coli*. They achieved great success in controlling sepsis, fever, and pain. They found that removal of the eschar was associated with less bleeding and less pain, and that the necessity of skin grafting was markedly diminished.

The use of 0.5% silver nitrate in a constant wet dressing for burns was instituted on a trial basis on the surgical service of the Apia General Hospital in 1966. Since that time, in a two-year period,

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TABLE 1.—*Pediatric cases.*

CASE	SEX	AGE	LOCATION OF PYODERMA	CULTURE	RESULT
1	F	2	Legs	Staph. aureus, coag. positive beta-strep., group undetermined.	Healed within 5 days.
2	M	1	Generalized	Staph. aureus, coag. positive beta-strep., group undetermined.	Healed within 13 days.
3	M	6	Generalized	Staph. aureus, coag. positive beta-strep., group undetermined. Diphtheroids.	Healed within 6 days.
4	M	9/12	Foot	Staph. aureus, coag. positive beta-strep., group undetermined.	Healed within 6 days.
5	F	2	Ear	Staph. aureus, coag. positive beta-strep., group A. Aerobacter aerogenes.	Healed within 7 days.
6	M	3	Ear	Staph. albus, coag. negative beta-strep., group A. Diphtheroids.	Healed within 4 days.
7	M	4	Generalized	Staph. aureus, coag. positive beta-strep., group A. Diphtheroids.	Healed within 7 days.
8	M	2	Foot	Staph. aureus, coag. positive beta-strep., group A. Diphtheroids.	Healed within 7 days.
9	M	3	Feet	Staph. aureus, coag. positive beta-strep., group A.	Almost healed at end of 7 days.
10	M	2	Feet	Staph. aureus, coag. positive beta-strep., group A. Diphtheroids.	Healed within 5 days.

it has been used in over 30 patients and is now standard treatment for all burns. No complications due to the use of the solution have been noted. The results of treatment have been very gratifying.

In using the silver nitrate solution, hospitalization is usually necessary in order for dressings to be changed at intervals (8, 12, or 24 hours, depending on the stage of healing), and in order to keep the dressings from drying out by the frequent addition of solution to the dressing. In addition, the soiling of clothing, linens, and basins is a problem best dealt with in the hospital.

Many patients, however, are ambulatory and well enough to be at home during convalescence, while epithelialization is taking place, except for the changing and wetting of dressings.

An idea to obviate the wet dressing problem led to the compounding of an ointment containing 0.5% silver nitrate. The base used was as follows:

Cetyl alcohol	47 gm
White beeswax	21 gm
Propylene glycol	31 gm
Sod. lauryl sulfate	6 gm
Liquid paraffin	56 gm
Water distilled	240 cc

To this was added 2 gm of silver nitrate crystals, incorporated by dissolving them in a minimum of distilled water and rubbing them into the base. This resulted in an ointment with a silver nitrate percentage of about 0.5, which was non-greasy, inexpensive, and easily washable from the skin.

The ointment was used initially on two cases of burns that were healing. Each still had defects of granulation tissue with marginal epithelialization. In one, culture revealed *Pseudomonas pyocyanea*. The ointment was applied once daily and covered with sterile gauze. After several days' application, the wounds were dry and completely epithelialized.

Subsequently the ointment was used in a series of ten pediatric patients with pyoderma, in most cases secondary to scabies. Nine of these patients were treated as outpatients, the final one being admitted to the hospital because of the extent of the lesions. Results of this series are summarized in Table 1. The ointment was found to be very effective, and no complications of treatment were encountered.

SUMMARY AND CONCLUSIONS

Silver nitrate ointment, 0.5%, has been employed as an extension of the use of a solution of 0.5% silver nitrate in the treatment of burns. It is particularly adapted to outpatient burn cases. Its effectiveness has been apparent also in the treatment of common pyodermas. Its advantages are safety, a wide range of bacteriostatic effectiveness, and inexpensiveness.

REFERENCE

1. Moyer, C. A., Brentano, L., Graves, D. L., Margraf, H. W., and Monafó, W. W., Jr.: Treatment of large human burns with 0.5% silver nitrate solution, *Arch. Surg.* 90:812-867 (June) 1965. ■

Coconut Oil as a Dietary Source of Fat with Special Reference to Filled Milk*

Y. E. DAVIS, M.S., and J. R. BEATON, Ph.D., Honolulu

● Weanling and young male rats were fed cow's milk, commercial filled milk (in which coconut oil-cottonseed oil replaced butterfat), and dry simulated milk diets in which the fat was corn oil, butter, coconut oil, or coconut oil with added linoleic acid. Measurements were made of food intake, body weight, body composition, and plasma and liver cholesterol levels.

Coconut oil feeding was associated with decreased food intake and body weight gain although weight gain per 100 calories consumed was superior to butter diets. The decreased body weight gain was explained in large part by a lower body content of moisture and fat. Plasma cholesterol was increased and liver cholesterol was decreased in rats fed coconut oil as the sole source of dietary fat. These alterations were eliminated by inclusion of cottonseed oil or of linoleic acid in the diet. A significant inverse relationship was shown to exist between plasma and liver cholesterol levels as affected by dietary fat.

THE RECENT introduction of imitation milk, more correctly called filled milk, in Hawaii has again raised questions of the nutritive value of coconut oil as the major source of dietary fat in support of growth and, in particular, in relation to plasma cholesterol levels. There have been a number of previous investigations in which the nutritive value of coconut oil along with other vegetable oils was compared with that of butterfat. Unfortunately, reports have been contradictory due in part at least to the use of different animals, strains, and ages and to multiple alterations of dietary constituents. To illustrate these contradictions, reference is made to a few pertinent reports.

In 1940, Harris and Mosher¹ reported that adolescent rats fed a semi-purified, dry diet showed greater weight gain with coconut oil as

the source of fat than with butterfat. In the same year, Schantz et al.² reported greater weight gain and better appearance in rats given a butterfat diet than in those provided with coconut oil, corn oil, cottonseed oil, or soybean oil, when the fats were homogenized in mineralized skim milk. Boutwell et al.³ noted an apparent effect of dietary carbohydrate; when lactose was the only carbohydrate fed, growth rate of rats was superior with butterfat, but with mixed carbohydrates, rats fed coconut oil showed superior growth.

Much of the criticism of the use of coconut oil has been in relation to its possible effects on cholesterol metabolism. Coconut oil, unlike other vegetable oils, has been reported to elevate serum or plasma cholesterol levels. It is almost devoid of polyunsaturated fatty acids and is notably high in saturated fatty acids, especially lauric acid (approximately 45% of its fatty acid content). On the other hand, certain beneficial effects have been reported. For example, it has been reported to have a sparing action on the essential fatty acid, linoleic acid.⁴ Medium chain triglycerides, such as found in coconut oil, have been stated to decrease the liver content of cholesterol.^{5, 6}

Since it was apparent that no clear-cut demonstration of the beneficial or deleterious effect of dietary coconut oil is available, the present ex-

TABLE 1.—Composition of commercial coconut oil-filled milk and cow's whole milk.

CONSTITUENT	FILLED MILK AMOUNT IN 1 QUART (976 GM)	COW'S WHOLE MILK AMOUNT IN 1 QUART (976 GM)
Protein, gm	32.50	32.30
Carbohydrate, gm	47.50	45.30
Fat, gm	32.20*	32.20†
Calcium, gm	1.16	1.15
Phosphorus, gm	0.92	0.91
Iron, mg	trace	trace
Vitamin A, I.U.	2000‡	1366§
Thiamine, mg	0.29	0.29
Riboflavin, mg	1.67	1.66
Niacin, mg	9.10	9.10
Ascorbic acid, mg	10.0	10.0
Vitamin D, I.U.	400	400

* Coconut oil 95%, cottonseed oil 5%.
† Butterfat.
‡ Fortified with vitamin A palmitate.
§ Year-round average.

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From the Department of Food and Nutritional Sciences, University of Hawaii.
Received for publication November 29, 1968.
Based in part upon a thesis (Y.E.D.) submitted to the University of Hawaii in partial fulfillment of the requirements for the M.S. degree in nutrition.

TABLE 2.—Composition in percent by weight of experimental diets.

CONSTITUENT	20% CASEIN	CORN OIL	COCONUT OIL	BUTTER	COCONUT OIL— COTTONSEED OIL
Casein	16	23.5	23.5	23.5	23.5
Vitaminized casein*	4	4	4	4	4
Lactose	32	40	40	40	40
Starch	32	---	---	---	---
Corn oil	10	26.6	---	---	---
Coconut oil	---	---	26.6	---	21.6
Cottonseed oil	---	---	---	---	5.0
Butter	---	---	---	30.9‡	---
Salts†	4	4	4	4	4
Alphacel	2	2	2	2	2
Cals/gram	4.26	4.80	4.80	4.65	4.80

* To 800 g casein, the following amounts of vitamins were added (in mg): thiamine chloride 100, niacin 900, riboflavin 200, pyridoxine hydrochloride 250, para-aminobenzoic acid 400, calcium pantothenate 400, biotin 20, folic acid 20, menadione 10, alpha tocopherol 2000, vitamin A palmitate 400 units, vitamin D₂ 50 units.

† Phillips, P. H., and Hart, E. B.: J. Biol. Chem. 109:657 (Mar.) 1935.

‡ Butter contains 14% water.

periments were undertaken in an attempt to clarify the situation, at least with respect to milk and simulated milk diets.

METHODS AND MATERIALS

Weanling and young male rats of the Fisher strain were housed in individual, screen-bottomed cages at an environmental temperature of 24 ± 1°C. and with 12 hours' light and 12 hours' darkness daily. Experimental diets and drinking water were provided ad libitum and body weights and food intakes were measured at regular intervals. At the end of the specified experimental feeding periods, the rats were anesthetized with pentobarbital sodium (6 mg/100 gm body weight); blood was obtained by hypodermic syringe from the exposed heart and heparinized. Plasma was separated by centrifugation for assay of cholesterol. Liver was removed, weighed, and an aliquot used for the determination of cholesterol. In one experiment, carcasses were analyzed for water, fat, and protein contents.

Cholesterol was determined in plasma and liver by the Liebermann-Burchard reaction as described by Natelson.⁷ For liver, prior extraction of cholesterol was accomplished by homogenizing the tissue in chloroform: methanol (2:1, V/V) to produce a 2% homogenate. After standing one hour with occasional swirling, the extract was filtered and the filtrate was assayed. Carcass water was meas-

ured by drying the whole carcass to constant weight at 80-90°C. The dried carcass was then carefully ground and thoroughly mixed. Aliquots were taken for analysis of protein by the micro Kjeldahl procedure (using the factor 6.25 to convert nitrogen to protein values) and for total fat by the modified Liebermann procedure of Gavin and McHenry.⁸

The compositions of the commercial cow's milk and filled (imitation) milk, and of the experimental dry diets are shown in Tables 1 and 2. The simulated milk diets differed only in the nature of the fat. They were approximately isocaloric, and were formulated on the basis of the composition of milk with the water removed. Three experiments were carried out as described individually. Statistical significance of difference between means was assessed by application of the student's t test. In one experiment, the correlation coefficient between plasma and liver cholesterol levels was determined.

Effect of Coconut Oil in Simulated Milk Diets on Body Weight and Cholesterol Levels

Eighteen weanling rats were divided into three groups of six animals each. One group was provided with each of the following simulated milk diets: corn oil, coconut oil, or butter. After 21 days' feeding, the animals were killed and plasma and liver cholesterol levels were determined.

TABLE 3.—Body weight gains and cholesterol levels in weanling rats fed simulated milk diets (results expressed as mean ± S.E.M.)

DIET GROUP	FOOD INTAKE		BODY WEIGHT GAIN g/rat/21 days	CHOLESTEROL	
	g/rat/day	Cals/rat/day		Plasma mg/100 ml	Liver mg/g
(1) Corn oil	8.5 ± 0.070	41.1 ± 0.339	87.7 ± 4.103	31 ± 3.39	7.2 ± 0.30
(2) Coconut oil	8.2 ± 0.303	39.7 ± 1.466	82.0 ± 3.130	87 ± 9.66	3.4 ± 0.40
(3) Butter	9.6 ± 0.250	44.2 ± 1.162	89.3 ± 4.104	53 ± 10.81	4.9 ± 0.52
Probability, P (1) vs (3) < 0.001			(1) vs (2) < 0.01	(1) vs (3) < 0.001	
(2) vs (3) < 0.001			(2) vs (3) < 0.05	(2) vs (3) < 0.05	

TABLE 4.—Body compositions of weanling rats fed fluid and dry, simulated milk diets (results expressed as mean \pm S.E.M. for 8 rats/group).

DIET	MOISTURE		FAT		PROTEIN	
	%	g	%	g	%	g
Cow's milk	72.0 \pm 0.336	70.4 \pm 4.546	7.2 \pm 0.833	7.0 \pm 1.039	16.9 \pm 0.311	16.5 \pm 1.132
Filled milk	72.4 \pm 1.228	59.1 \pm 12.721	6.6 \pm 0.603	5.4 \pm 1.854	17.1 \pm 0.808	14.0 \pm 2.519
Butter diet*	64.7 \pm 0.653	110.4 \pm 7.048	13.7 \pm 1.014	22.8 \pm 1.014	17.5 \pm 0.302	29.4 \pm 0.956
Coconut oil-cottonseed oil diet*	68.2 \pm 0.379	97.2 \pm 4.207	10.3 \pm 1.386	14.8 \pm 1.026	17.7 \pm 0.240	25.2 \pm 1.145

* These simulated milk diets were fed for 14 days after feeding fluid milks for 14 days.

Effect of Fluid Imitation and Cow's Milk on Body Weight and Cholesterol Levels

Thirty-two weanling rats were divided into two groups of 16 animals each. For the first 14 days, one group received fresh cow's whole milk; the other group received a commercial filled milk in which butterfat had been replaced by coconut oil and cottonseed oil. At the end of this first 14 days, eight animals of each group were killed for analysis. The remaining animals were fed simulated cow's milk and imitation milk diets; the group previously fed cow's milk received the butter diet while the group previously fed the filled milk received the coconut oil-cottonseed oil diet. At the end of a further 14 days' experimental feeding, these animals were killed for analysis. Plasma and liver cholesterol levels and carcass compositions were determined.

Effect of Addition of an Essential Fatty Acid to Coconut Oil

Fifty-six young male rats weighing 90-110 gm were divided into seven comparable groups. Groups were fed one of the following dry diets for 20 days: 20% casein control, corn oil, butter, coconut oil, coconut oil + 1.33% linoleic acid, coconut oil + 2.66% linoleic acid, coconut oil + 5.32% linoleic acid (methyl linoleate was added at the expense of coconut oil so that the total dietary fat remained constant). At the end of the 20-day period, the animals were killed and plasma and liver cholesterol levels were determined.

RESULTS

As shown in Table 3, animals fed the simulated

diet containing coconut oil as the only source of fat, had a slightly, but not significantly, lower body weight gain following 21 days' feeding. In these animals, plasma cholesterol level was significantly higher and liver cholesterol level significantly lower than in those animals fed corn oil or butter diets.

As shown in Figure 1, rats fed fluid filled milk gained significantly less weight than did rats fed

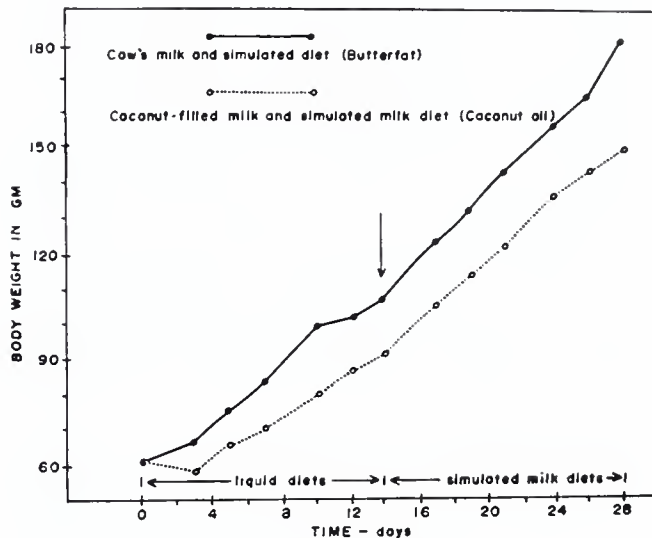


FIG. 1.—Average body weight gains of rats fed cow's milk or filled milk for 14 days followed by feeding of dry, simulated milk diets for a further 14 days. Each point till the 14th day is the mean value for 16 rats and from the 17th to 28th day is for eight rats.

cow's milk ($P < 0.01$). However, with subsequent provision of dry, simulated diets, average weight gains were comparable (63.5 gm for butter diet and 58.1 gm for coconut oil-cottonseed oil diet). Calorie intakes in g/rat/day differed: 38.3 cow's milk, 34.1 filled milk, 66.2 butter diet, 48.0 co-

TABLE 5.—Plasma and liver cholesterol levels in weanling rats fed fluid and dry, simulated milk diets (results expressed as mean \pm S.E.M. for 8 rats).

DIET	PLASMA CHOLESTEROL		LIVER CHOLESTEROL	
	mg/100 ml		mg/g	
(1) Cow's milk	67.4 \pm 9.249	3.8 \pm 0.244	18.6 \pm 1.174	
(2) Filled milk	68.7 \pm 10.015	3.2 \pm 0.271	14.6 \pm 2.347	
(3) Butter diet	84.4 \pm 6.139	4.9 \pm 0.286	42.4 \pm 1.304	
(4) Coconut oil-cottonseed oil diet	88.7 \pm 11.255	6.2 \pm 0.565	41.1 \pm 3.746	
Probability, P	(1) vs (3) < 0.01		(1) vs (3) < 0.001	
	(3) vs (4) < 0.01		(2) vs (4) < 0.001	

conut oil–cottonseed oil diet. These calorie intake differences may explain in part the lower weight gain of rats fed fluid diets as compared with those fed dry diets. These differences in weight gain may also be explicable on the basis of the low vitamin and mineral contents of the fluid milks. Data on body compositions are set down in Table 4. From these data, it is apparent that the differences in final body weights may be explained in large part by differences in moisture and fat contents: i.e. rats fed coconut oil–cottonseed oil diets had less moisture and fat (but comparable protein) than did those fed butter diets. Cholesterol levels shown in Table 5 demonstrate that there were no differences in plasma or liver cholesterol levels between rats fed cow’s milk or commercial filled milk. With dry, simulated milk diets there was no difference in plasma or liver total cholesterol values although a significant elevation was noted in liver cholesterol concentration of rats fed the coconut oil–cottonseed oil diet. From these results, it appears that addition of cottonseed oil prevented the elevation of plasma cholesterol and decrease of liver cholesterol observed in the first experiment with coconut oil as the sole source of dietary fat. The elevation of plasma and liver cholesterol levels of rats fed dry diets compared with those of fluid diets is of interest. This would not seem to be an effect of age difference since this was only 14 days; since animals fed the dry diets had a greater calorie intake, a possible relationship between calorie intake and cholesterol level should be considered.

In the third experiment, the role of a dietary essential fatty acid was examined. Results of body weight gains and food and calorie intakes are set down in Table 6. As in the previous experiments, rats fed coconut oil diets consumed slightly less food and gained slightly less weight than did rats fed corn oil or butterfat diets, although these differences were not significant. It is of considerable interest however, that rats fed the coconut oil diet gained more weight per 100 calories consumed, indicating a greater efficiency of food utilization for synthetic purposes. As observed in

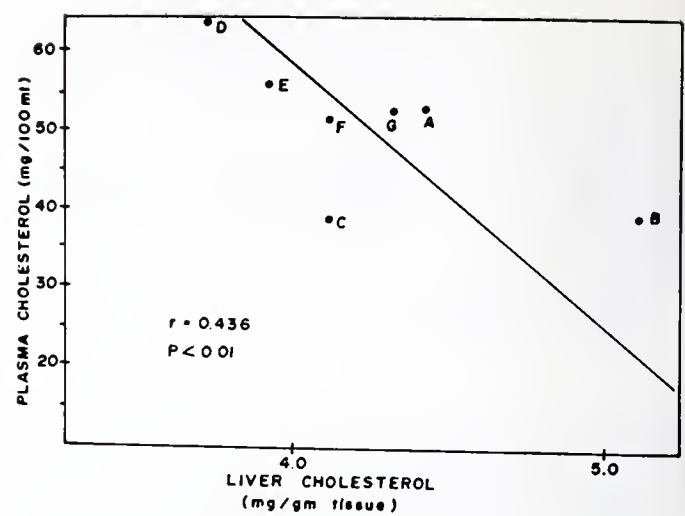


FIG. 2.—Inverse correlation between plasma and liver cholesterol concentrations as affected by dietary fat: A—20% casein; B—corn oil; C—butter; D—coconut oil (C.O.); E—C.O. + 1.33% linoleic acid; F—C.O. + 2.66% linoleic acid; G—C.O. + 5.32% linoleic acid. Each point represents the mean value for eight rats.

the first experiment, rats fed the simulated filled milk diet (coconut oil) had increased plasma and decreased liver cholesterol concentrations compared with those fed the simulated cow’s milk (butter) diet. With addition of methyl linoleate to the coconut oil, these differences disappeared, i.e. plasma cholesterol decreased and liver cholesterol increased. When plasma cholesterol levels were plotted against liver cholesterol levels, shown in Figure 2, a significant negative correlation was obtained thus demonstrating an inverse relationship and presumably, interdependence.

DISCUSSION

From the results of these experiments, certain conclusions can be drawn concerning the nutritive value of coconut oil-filled milk and dry, simulated milk diets—at least with respect to weanling and young male rats.

Substitution of coconut oil or coconut oil–cottonseed oil for butterfat leads to a reduced food intake and body weight gain with both fluid and dry diets. However, it should be noted that the reduced body weight gain can be explained largely

TABLE 6.—Food intake, calorie intake, and plasma and liver cholesterol levels of young, male rats fed simulated milk diets with additions of linoleic acid (results expressed as mean ± S.E.M. for 8 rats).

DIET	FOOD INTAKE g/rat/day	CALORIE INTAKE rat/day	BODY WEIGHT GAIN g/rat/day	g/100 Cals.	PLASMA CHOLESTEROL mg/100 ml	LIVER CHOLESTEROL mg/g	total mg
20% casein control	17.3 ± 0.255	73.7	6.2 ± 0.101	8.4	52.8 ± 9.292	4.4 ± 0.504	60.2 ± 6.890
Corn oil	12.7 ± 0.319	64.6	5.1 ± 0.426	6.6	39.1 ± 6.369	5.1 ± 0.437	65.3 ± 5.594
Butter	13.1 ± 0.448	65.6	5.0 ± 0.171	7.6	38.4 ± 4.680	4.1 ± 0.321	51.5 ± 4.032
Coconut oil (C.O.)	11.7 ± 0.448	59.6	4.8 ± 0.087	8.1	63.1 ± 7.165	3.7 ± 0.349	44.4 ± 4.191
C.O. + 1.33% M.L.*	12.9 ± 0.251	65.7	5.1 ± 0.174	7.8	55.9 ± 9.608	3.9 ± 0.398	48.2 ± 5.051
C.O. + 2.66% M.L.*	13.5 ± 0.271	68.7	5.4 ± 0.112	7.9	51.1 ± 6.399	4.1 ± 0.250	50.6 ± 3.082
C.O. + 5.32% M.L.*	12.6 ± 0.284	63.0	4.9 ± 0.149	7.8	52.2 ± 8.422	4.3 ± 0.266	49.1 ± 2.966

* Methyl linoleate added at the expense of coconut oil.

on the basis of a decreased body content of moisture and fat. In a long-term study with rats fed high-fat diets, Barboriak et al.⁹ observed that more fat storage was observed with milk fat-fed rats than with those fed diets containing coconut oil. Our results with short-term feeding are in agreement with this observation. In view of the current concern with body fat and obesity, it may well be that the decrease observed with coconut oil feeding may be of ultimate benefit in terms of disease and longevity. This hypothesis cannot be substantiated by the present limited data but it does deserve additional investigation. Further, it is of interest that with coconut oil feeding, body weight per 100 calories consumed was somewhat greater than with butter feeding; this is indicative of a more efficient utilization of nutrients.

Although coconut oil feeding was associated with an increased plasma cholesterol level, it is of considerable interest that under these conditions, a decreased concentration of cholesterol in liver tissue was observed in agreement with the conclusions of others.^{5, 6} It is wondered if the cholesterol concentration in liver reflects the concentration in other tissues since cholesterol is synthesized in liver. Should cholesterol reach a tissue, it must be either transported from that tissue or remain as a stored substance since it cannot be destroyed completely. It is because of this virtual indestructibility of the cholesterol molecule that its accumulation in tissues such as arteries and the gallbladder may cause disease.

Addition of cottonseed oil (high in linoleic acid) as in the commercial filled milk and of methyl linoleate in the simulated filled milk diets prevented the increase of plasma cholesterol and decrease of liver cholesterol levels. That these levels are related and possibly interdependent is suggested by our observation of a significant inverse correlation of these levels as altered by the nature of the dietary fat. The mechanism whereby linoleic acid brings about these effects is unknown, i.e. whether by altering cholesterol excretion, synthesis, or transport. Further studies will be required to determine this.

The saturated fatty acids in coconut oil have been postulated to explain the increase of plasma cholesterol levels in both human and animal studies^{10, 11} and it has been reported that the shorter the chain length, the greater the elevation of plasma cholesterol level.¹² In apparent contrast, Hashim et al. have concluded that the medium chain triglycerides of coconut oil do not elevate plasma cholesterol in man.¹³ It should be noted that differing from the studies of some

others, our experimental diets were cholesterol-free. Thus, any possible effects of dietary fat on cholesterol absorption would not appear. However, our observations do support the hypothesis that coconut oil feeding elevates plasma cholesterol and that this elevation can be eliminated by inclusion in the diet of the essential fatty acid, linoleic acid. It would appear therefore, that the elevated plasma cholesterol level is a consequence of the absence of essential fatty acids rather than to a specific effect of those saturated fatty acids which are present in coconut oil. A new observation derived from our experiments is the observed decrease of liver cholesterol level associated with coconut oil feeding and the reversal of this effect by inclusion of dietary linoleic acid. If liver tissue concentration is indicative of the cholesterol deposition in other tissues, it is possible that the feeding of coconut oil is beneficial despite the elevated plasma cholesterol level and that addition of essential fatty acids or of oils containing essential fatty acids may not be beneficial. However, this must remain as speculation until such time as it may be substantiated by further quantitative, definitive studies.

ACKNOWLEDGMENTS

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REFERENCES

1. Harris, R. S., and Mosher, L. M.: Comparison of nutritive value of refined coconut oil and butterfat, *Food Res.* 5:177 (Jan.-Feb.) 1940.
2. Schantz, E. J., Elvehjem, C. A., and Hart, E. B.: The comparative nutritive value of butterfat and certain vegetable oils, *J. Dairy Sci.* 23:181 (Feb.) 1940.
3. Boutwell, R. K., Geyer, R. P., Elvehjem, C. A., and Hart, E. B.: Further studies on the growth-promoting value of butterfat, *J. Dairy Sci.* 26:429 (May) 1943.
4. Kaunitz, H., Slanetz, A., Johnson, R. E., and Barbaryan, V. K.: Medium-chain and long-chain saturated triglycerides and linoleic acid requirements, *J. Nutrit.* 71:400 (Aug.) 1960.
5. Kaunitz, H.: Dietary fat and tissue lipids in experimental nephrosis, *Metabolism* 11:1187 (Nov.) 1962.
6. Grande, F.: Dog serum lipid responses to dietary fats differing in the chain length of the saturated fatty acids, *J. Nutrit.* 76:255 (Mar.) 1962.
7. Natelson, S.: *Microtechniques of Clinical Chemistry*, 2nd edition, 1966, C. C. Thomas Publisher.
8. Gavin, G., and McHenry, E. W.: The B vitamins and fat metabolism. III The effects of vitamin B₆ upon liver and body fat, *J. Biol. Chem.* 132:41 (Jan.) 1940.
9. Barboriak, J. J., Krehl, W. A., Cowgill, G. R., and Whedon, A. D.: Influence of high-fat diets on growth and development of obesity in the albino rat, *J. Nutrit.* 64:241 (Feb.) 1958.
10. Ahrem, E. M., Hirsch, J., Insull, W., Tsattas, T. T., Blomstrand, R., and Peterson, M. L.: Dietary control of serum lipids in relation to atherosclerosis, *JAMA* 164:1905 (Aug. 24) 1957.
11. Hegsted, D. M., Andrus, S. B., Gotsis, A., and Portman, O. W.: The quantitative effects of cholesterol, cholic acid and type of fat on serum cholesterol and vascular sudanophilia in the rat, *J. Nutrit.* 63:273 (Oct.) 1957.
12. Beveridge, J. M. R., Connell, W. F., and Mayer, G. A.: The nature of the substances in dietary fat affecting the level of plasma cholesterol in humans, *Canad. J. Biochem. Physiol.* 35: 257 (Apr.) 1957.
13. Hashim, S. A., Clancy, R. E., Hegsted, D. M., and Stare, F. J.: Effect of mixed fat formula feeding on serum cholesterol in man, *J. Clin. Nutrit.* 7:30 (Jan.-Feb.) 1959. ■

*About as much surgery is done in Honolulu hospitals
as in mainland ones—but much more obstetrics.*

Short-Stay Hospital Discharges on Oahu

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● *Short hospital stays on Oahu involve about 116.6 persons annually per 1,000 population; the mainland rate is about 15 per cent higher. Caucasians have the most, followed by Filipino, and Japanese the least. Obstetrics accounts for 22.2 per cent of all discharges on Oahu—and 15 per cent on the mainland. Sixty per cent of hospitalizations were for surgery, about the same as on the mainland. Length of stay averaged 5.6 days for male patients, 4.3 for female—somewhat less than on the mainland.*

DATA FOR THIS report were obtained primarily from the "Oahu Health Surveillance Program." This was a monthly health survey on the island of Oahu conducted from April, 1964, through March, 1967, by the Research and Statistics Office and the Public Health Nursing Branch of the State Health Department. The project was funded in part by the U. S. Public Health Service. Information was secured by means of interviews in a monthly random sample of all households on the island.

Only the resident noninstitutional population was included. Tourists and other nonresidents, persons in institutions for long-term care, and members of the armed forces living in barracks were excluded. The military not in barracks, together with members of their families, were included in the monthly sample.

At each household in the sample, questions were asked relative to hospitalization which any member of the household might have experienced during the twelve-month period prior to the interview. The questionnaire used contained also other items of information, such as age and sex, which could be related to hospitalization.

Such household interviews obtained information only about persons alive at the time of interview. Hospital experience during the reference period among persons who died during that period prior to the time of interview was not included. Consequently, to make estimates of the total number of hospital discharges, it was necessary to adjust the volume of discharges from interview data to include the hospital experience of deceased persons.

This was made feasible through a second type of survey whereby information concerning hospitalization during the last year of life was obtained on a monthly ten per cent sample of deaths occurring on Oahu from August, 1964, through March, 1967. The principal sources of information were the death certificate, and the hospital which provided medical and personal care for the decedents during the twelve-month period preceding death. In addition, some surviving relative of a decedent or the funeral director was sometimes asked to provide information which would be helpful in locating hospitals which provided care. For the most part, the survey was conducted by mail.

NOTES ON STUDY DESIGN

Data in this report from both interviews and the mail survey of decedents refer only to short-stay hospitals as defined by the American Hospital Association. On Oahu, this included the following hospitals: Castle Memorial, Ewa Plantation, Kahuku, Kaiser Foundation, Kapiolani, Children's, Kuakini, Leeward, Queen's, St. Francis, Tripler, Wahiawa General, and Waialua Agricultural.

About 95.7 per cent of the discharges included in this report were from these Oahu hospitals. The remaining 4.3 per cent were from short-stay hospitals on the mainland, on the neighbor islands, and in foreign countries.

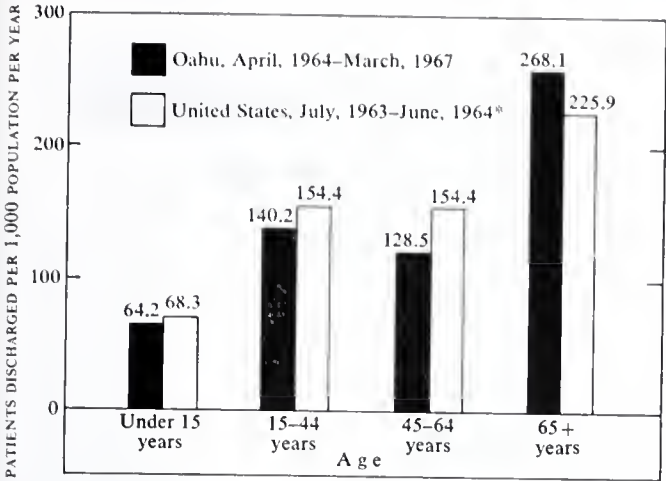
A hospital discharge was considered the com-

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* The authors are research statisticians of the State Department of Health.

† Deceased.

CHART 1.—Average number of patients discharged per 1,000 population per year by age: Oahu and United States.



* From National Center for Health Statistics, Report No. 30, Series 10.

pletion of any continuous period of one or more nights in a hospital, as an inpatient, except the period of stay of a well newborn infant. Therefore, this report does not include inpatients who were admitted and discharged the same day.

In a health interview survey, methodological studies have found under-reporting of hospitalizations due to the failure of respondents to recall hospital experience. Following a procedure of the national health interview survey, an adjustment for the under-reporting of hospitalization due to memory bias was made by deriving estimates on hospital discharges from experience reported during the most recent six months prior to interview and adjusting this figure to represent 12 months' experience. This increased the number of sample discharges (2,600) by nearly 11 per cent.

The hospitalization history during the last year of life of 515 decedents was used. These had 896 hospital discharges, averaging 1.7 per patient. The health survey sample with hospitalization during the past year averaged 1.2 discharges per patient.

Concepts, definitions, and methods in both the

local health interview survey and the survey of decedents on Oahu were similar to those used in the continuous national health interview survey carried on by the National Center for Health Statistics, U.S. Public Health Service. A publication of that agency entitled *Hospital Discharges and Length of Stay: Short-Stay Hospitals, United States, July 1963–June 1964* contains data comparable to those in this report. It also includes a description of how the Federal work was conducted and gives references to other related publications.

Although the time period covered was not exactly the same in the Federal study, all country-wide data used in this report for comparison with Oahu are from the above Federal publication. No other publication or study that we know of combines hospital information from a health interview survey with that on decedents during the last year of life.

CHARACTERISTICS OF DISCHARGES

The average annual number of patients discharged during the period of the survey was approximately 66,500 (Table 1). Slightly more than 60 per cent were females, of whom more than one-third came to the hospital for delivery.

The number of patients discharged per 1,000 population was 92.4 for males and 139.7 for females. Excluding deliveries, the rate for females was only 88.8.

As would be expected, excluding delivery cases, discharge rates increased with age. For example, the rate for those under 17 years was only 62.3 compared to 268.1 for those 65 and over.

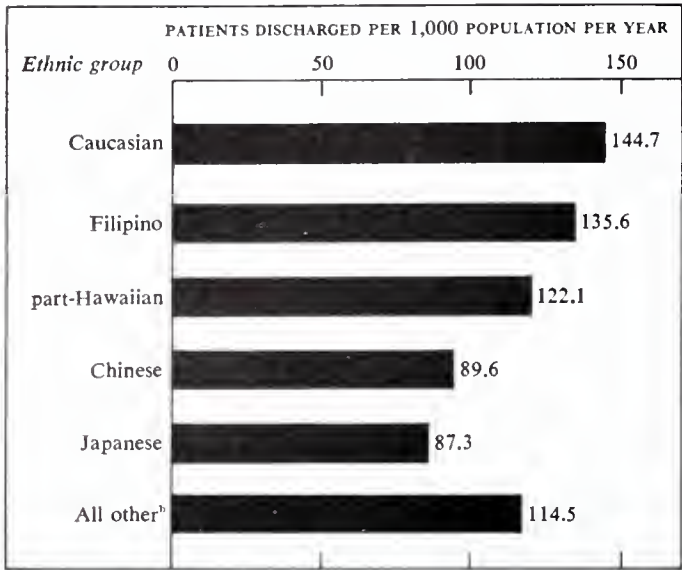
Chart 1 shows Oahu discharge rates compared with those for the United States as a whole. At ages under 65, the U.S. rates were somewhat higher, but at 65 and over the Oahu rate was higher. Other data indicate that this higher Oahu rate was due to males, since the rate for women 65 and over was about 10 per cent higher in the

TABLE 1.—Estimated Average Annual Number of Short-Stay Hospital Discharges and Rate per 1,000 Population by Sex and Age: Oahu, April, 1964–March, 1967.

AGE	AVERAGE ANNUAL NUMBER OF PATIENTS DISCHARGED			NUMBER OF PATIENTS DISCHARGED PER 1,000 POPULATION PER YEAR		
	Both sexes	Male	Female	Both sexes	Male	Female
	66,500	25,800	40,700	116.6	92.4	139.7
Under 17 years	14,100	7,900	6,200	62.3	71.1	53.8
17–44 years	34,300	7,800	26,500	149.3	71.7	219.4
45–64 years	11,600	6,100	5,500	128.5	127.4	129.8
65+ years	6,500	4,000	2,500	268.1	353.1	192.9

Note: Numbers of patients are rounded to the nearest 100.

CHART 2.—Average number of patients discharged per 1,000 population per year by ethnic group^a: April, 1964–March, 1967.



^a Rates are age-adjusted. ^b This category includes persons of unmixed ancestry not specified above and all those reporting mixed ancestry except part-Hawaiians.

country as a whole. On the other hand, the rate for men in the same age group was 46 per cent higher on Oahu. This phenomenon possibly may be related to the number of elderly oriental men without families still living in Hawaii.

Using age-adjusted rates, i.e., assuming that age distribution on Oahu was the same as in the country as a whole, the rate was about two per cent higher for males and ten per cent higher for females in the country as a whole. Making the same comparison, excluding deliveries, the country-wide rate for females was more than 20 per cent higher than for Oahu females.

By race or ethnic group, Caucasians had the highest discharge rate—144.7 per 1,000—and Japanese the lowest—87.3 per 1,000 (Chart 2). The percentage distribution of discharged patients showed Caucasians highest in volume, followed by Japanese, part-Hawaiian, Filipino, and Chinese (Chart 3).

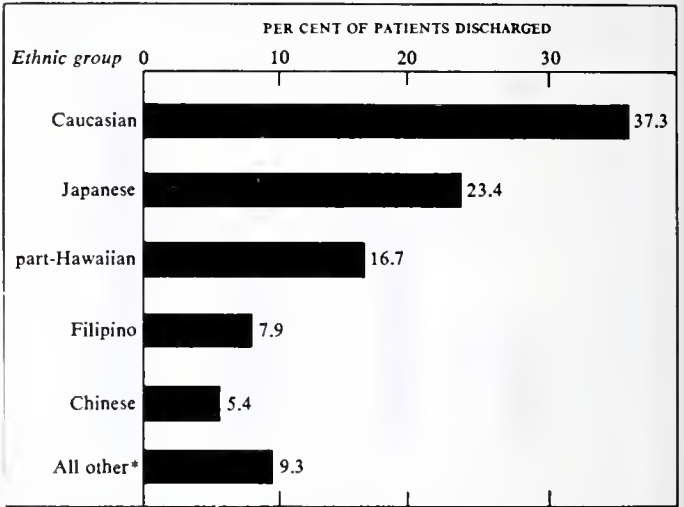
CONDITION FOR WHICH HOSPITALIZED

Where more than one condition was specified as responsible for hospitalization, only that one considered chiefly responsible was tabulated. If a person entered a hospital for diagnostic tests, or for an operation, the condition that made the tests or operation necessary was considered to be the condition for which hospitalized.

Normal delivery in a hospital was included as a “condition for which hospitalized,” but care of the well newborn infant was not.

Conditions, except impairments, were coded by type according to the International Classification of Diseases as modified by the National Center for

CHART 3.—Percentage distribution of patients discharged by ethnic group: Oahu, April, 1964–March, 1967.



* This category includes persons of unmixed ancestry not specified above and all those reporting mixed ancestry except part-Hawaiian.

Health Statistics to make the code more suitable for the interview type of survey. Impairments were coded according to a special supplementary classification devised by the Center.

The major cause of hospitalization on Oahu was delivery of mothers. This accounted for 22.2 per cent of all discharges and 36.3 per cent of all those for females (Table 2).

In the country as a whole, deliveries constituted only 15.4 per cent of all discharges and only 25.3 per cent of all those for females (from citation above). These differences reflect not only the higher birth rate in Hawaii but also the fact that a larger proportion of births occur here in hospitals than in the country as a whole.*

Among Oahu males, the leading causes of hospitalization were: respiratory conditions, 15.0 per cent; injuries, 13.1 per cent; genitourinary system conditions, 7.6 per cent; and diseases of the heart, 7.5 per cent.

Among females, leading causes other than delivery were: respiratory conditions 11.0 per cent; breast and genital disorders, 5.3 per cent; benign and unspecified neoplasms, 5.2 per cent; and injuries 5.1 per cent.

Table 3 shows conditions causing hospitalization by three age groups. The leading cause for those under 17 years was respiratory conditions, accounting for 32.4 per cent of all discharges in that age group. Among persons 17 to 44, the leading cause was, of course, delivery, with 42.8 per cent hospitalized for that reason. Among persons aged 45 and over, diseases of the heart constituted the major cause, with 11.7 per cent hospitalized for that reason.

* According to the National Center for Health Statistics (Volume 1—Natality), the birth rate in 1965 was 19.4 births per 1,000 population in the country as a whole and 23.0 in Hawaii. During the same year, 97.4 per cent of the births in the country at large and 99.3 per cent in Hawaii occurred in hospitals.

TABLE 2.—Estimated Average Annual Number of Short-Stay Hospital Discharges and Per Cent Distribution by Condition for Which Hospitalized and Sex: Oahu, April, 1964–March, 1967.

CONDITION FOR WHICH HOSPITALIZED	AVERAGE ANNUAL NUMBER OF PATIENTS DISCHARGED			PER CENT DISTRIBUTION		
	Both sexes	Male	Female	Both sexes	Male	Female
All conditions	66,500	25,800	40,700	100.0	100.0	100.0
Infective and parasitic diseases	1,100	700	400	1.7	2.6	1.1
Malignant neoplasms	1,900	900	900	2.8	3.7	2.3
Benign and unspecified neoplasms	3,000	900	2,100	4.5	3.5	5.2
Diabetes mellitus	500	300	200	0.7	1.0	0.5
Other endocrine, allergic, and metabolic disorders	2,300	1,200	1,100	3.5	4.8	2.6
Mental, personality disorders, and deficiencies	500	200	400	0.8	0.8	0.9
Vascular lesions of the central nervous system	900	300	600	1.4	1.2	1.5
Diseases of the eye and visual impairments	1,200	400	700	1.7	1.7	1.6
Other diseases of nervous system and sense organs	1,500	700	800	2.3	2.6	2.1
Diseases of the heart, NEC	2,600	1,900	700	4.0	7.5	1.8
Hypertension without heart involvement	600	300	300	0.9	1.2	0.7
Varicose veins (excluding hemorrhoids)	500	200	300	0.7	0.8	0.6
Hemorrhoids	900	700	200	1.3	2.6	0.5
Other circulatory diseases	600	400	200	1.0	1.7	0.5
Upper respiratory conditions	3,800	1,700	2,100	5.7	6.6	5.2
Other respiratory conditions	4,600	2,200	2,400	6.8	8.4	5.8
Ulcer of stomach and duodenum	1,400	800	600	2.2	3.2	1.5
Appendicitis	1,100	700	400	1.7	2.7	1.1
Hernia	1,100	1,100	*	1.6	4.1	*
Diseases of the gallbladder	800	300	500	1.2	1.1	1.3
Other digestive system conditions	2,300	1,200	1,000	3.4	4.8	2.5
Male genital disorders	700	700	*	1.0	2.6	*
Female breast and genital disorders	2,100	*	2,100	3.2	*	5.3
Other genitourinary system conditions	2,200	1,300	900	3.3	5.0	2.2
Deliveries	14,800	*	14,800	22.2	*	36.3
Complications of pregnancy and the puerperium	1,600	*	1,600	2.4	*	3.9
Diseases of the skin	700	500	100	1.0	2.1	0.3
Arthritis, all forms	200	100	100	0.4	0.3	0.4
Conditions of bones and joints, NEC	1,400	800	600	2.1	3.1	1.5
Other conditions of the musculoskeletal system	800	300	400	1.1	1.2	1.1
Fractures and dislocations	1,800	1,000	700	2.6	3.9	1.8
Other current injuries	3,800	2,400	400	5.6	9.2	3.3
All other conditions and observations	3,400	1,600	1,900	5.2	6.0	4.6

* No cases or too few to meet standards of precision.
Note: Numbers of patients above are rounded to the nearest 100; consequently, they do not always add up exactly to totals. NEC signifies "not elsewhere classified."

SURGICAL TREATMENT

A surgical operation included any cutting or piercing of the skin or other tissue; stitching of cuts or wounds; setting of fractures and dislocations; and the introduction of tubes for drainage, "tapping," and terms ending in "scopy," e.g., cystoscopy. Deliveries were also counted as operations. On the other hand, injections and transfusions were not included. Routine circumcision also was not considered an operation.

Only operations performed in hospitals upon inpatients were included.

Operations were classified by type according to a condensed version of *Classification Codes for*

Surgical Operations and Procedures, published by the Bureau of Medical Services, U.S. Public Health Service.

Approximately 39,500 patients annually or 59.4 per cent of all discharges in the study had surgery during hospitalization (Table 4). Since "delivery" was considered as surgery, a volume of about 15,000 deliveries annually accounted for 37.5 per cent of all discharges with surgery and more than half (54.8 per cent) of female cases with surgery.

About 48 per cent of all males discharged had surgery compared with 66 per cent of females discharged. If deliveries are excluded, then the percentage of females with surgery was only 47.2 per cent, slightly less than the percentage for males.

TABLE 3.—Estimated Average Annual Number of Short-Stay Hospital Discharges and Per Cent Distribution by Condition for Which Hospitalized and Age: Oahu, April, 1964–March, 1967.

CONDITION FOR WHICH HOSPITALIZED	AVERAGE ANNUAL NUMBER OF PATIENTS DISCHARGED				PER CENT DISTRIBUTION			
	All ages	Under 17 years	17–44 years	45+ years	All ages	Under 17 years	17–44 years	45+ years
All conditions	66,500	14,100	34,300	18,100	100.0	100.0	100.0	100.0
Infective and parasitic diseases	1,100	400	500	200	1.7	2.8	1.5	1.0
Malignant neoplasms	1,900	100	500	1,300	2.8	0.9	1.3	7.1
Benign and unspecified neoplasms	3,000	500	1,500	1,000	4.5	3.2	4.5	5.6
Diabetes mellitus	500	*	100	300	0.7	*	0.4	1.6
Other endocrine, allergic, and metabolic disorders	2,300	800	700	900	3.5	5.6	1.9	4.8
Mental, personality disorders, and deficiencies	500	*	200	300	0.8	*	0.5	1.8
Vascular lesions of the central nervous system	900	*	*	800	1.4	*	*	4.5
Diseases of the eye and visual impairments	1,200	300	*	700	1.7	2.2	*	3.9
Other diseases of nervous system and sense organs	1,500	700	400	400	2.3	4.7	1.3	2.2
Diseases of the heart, NEC	2,600	*	400	2,100	4.0	*	1.3	11.7
Hypertension without heart involvement	600	*	300	200	0.9	*	1.0	1.3
Varicose veins (excluding hemorrhoids)	500	*	200	300	0.7	*	0.5	1.7
Hemorrhoids	900	*	600	300	1.3	*	1.7	1.7
Other circulatory diseases	600	*	200	400	1.0	*	0.6	2.3
Upper respiratory conditions	3,800	2,800	700	300	5.7	20.2	1.9	1.7
Other respiratory conditions	4,600	1,700	1,400	1,400	6.8	12.2	4.0	8.0
Ulcer of stomach and duodenum	1,400	*	700	700	2.2	*	2.2	3.8
Appendicitis	1,100	600	400	*	1.7	4.4	1.3	*
Hernia	1,100	600	300	200	1.6	4.4	0.8	1.0
Diseases of the gallbladder	800	*	300	400	1.2	*	1.0	2.3
Other digestive system conditions	2,300	500	900	900	3.4	3.4	2.7	4.8
Male genital disorders	700	*	*	500	1.0	*	*	2.5
Female breast and genital disorders	2,100	*	1,600	500	3.2	*	4.7	2.9
Other genitourinary system conditions	2,200	400	700	1,100	3.3	2.8	1.9	6.2
Deliveries	14,800	*	14,700	*	22.2	*	42.8	*
Complications of pregnancy and the puerperium	1,600	*	1,600	*	2.4	*	4.6	*
Diseases of the skin	700	300	300	100	1.0	1.9	0.8	0.8
Arthritis, all forms	200	*	*	100	0.4	*	*	0.8
Conditions of bones and joints, NEC	1,400	200	800	400	2.1	1.6	2.4	2.1
Other conditions of the musculoskeletal system	800	*	200	400	1.1	*	0.7	2.2
Fractures and dislocations	1,800	600	800	300	2.6	4.4	2.4	1.4
Other current injuries	3,800	1,100	2,000	600	5.6	7.8	5.9	3.3
All other conditions and observations	3,400	1,900	800	800	5.2	13.3	2.3	4.3

* No cases or too few to meet standards of precision.

Note: Numbers of patients above are rounded to the nearest 100; consequently, they do not always add up exactly to totals. NEC signifies "not elsewhere classified."

Chart 4 compares the percentage of discharges with surgery on Oahu and in the United States as a whole, excluding deliveries. The percentage was only slightly higher on Oahu, 47.8 per cent compared with 44.1. This difference was due largely to males since the percentage of females with surgery on Oahu (47.2) was nearly the same as the percentage for the country at large (46.0).

Including deliveries, the percentage of discharges with surgery was considerably higher on Oahu compared with the United States. This was simply for the reasons that the birth rate is higher

in Hawaii and the proportion of births occurring in hospitals greater.

Among about 118,000 discharges with surgical treatment during the three-year period of the survey, a total of 127,000 operations were performed upon Oahu residents. This was about seven per cent more operations than patients treated. It is, of course, not unusual to perform more than one operation on a single patient during a hospitalization. (Table 5 shows the average annual number of operations.)

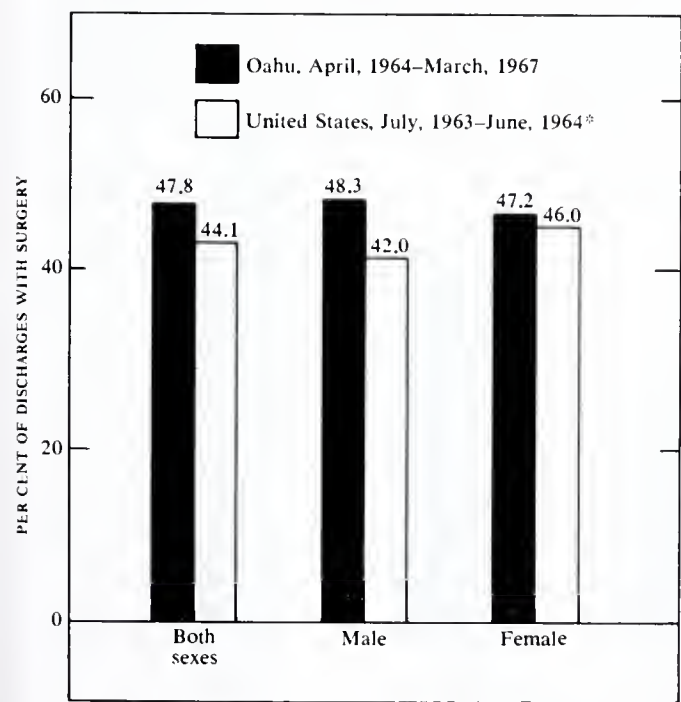
Delivery of mothers was by far the most fre-

TABLE 4.—Estimated Average Annual Number of Short-Stay Hospital Discharges and Rate per 1,000 Population by Sex, Age and Whether or Not Surgery Was Performed: Oahu, April, 1964–March, 1967.

HOSPITAL DISCHARGES WITH OR WITHOUT SURGERY	AVERAGE ANNUAL NUMBER OF PATIENTS DISCHARGED			NUMBER OF PATIENTS DISCHARGED PER 1,000 POPULATION PER YEAR		
	Both sexes	Male	Female	Both sexes	Male	Female
All ages						
Total	66,500	25,800	40,700	116.6	92.4	139.7
With surgery	39,500	12,500	27,000	69.3	44.7	92.8
Without surgery	27,000	13,300	13,700	47.3	47.7	46.9
Under 17 years						
Total	14,100	7,900	6,200	62.3	71.1	53.8
With surgery	7,200	4,300	2,900	31.9	38.4	25.5
Without surgery	6,900	3,600	3,300	30.4	32.7	28.3
17-44 years						
Total	34,300	7,800	26,500	149.3	71.7	219.4
With surgery	25,300	4,200	21,100	110.0	38.4	174.7
Without surgery	9,000	3,600	5,400	39.3	33.3	44.7
45-64 years						
Total	11,600	6,100	5,500	128.5	127.4	129.8
With surgery	5,000	2,800	2,200	55.2	57.4	52.7
Without surgery	6,600	3,300	3,300	73.3	70.0	77.1
65+ years						
Total	6,500	4,000	2,500	268.1	353.1	192.9
With surgery	2,000	1,300	700	83.4	112.9	57.3
Without surgery	4,500	2,700	1,800	184.7	240.2	135.6

Note: Numbers of patients are rounded to the nearest 100; consequently, they do not always add up exactly to totals.

CHART 4.—Percent of discharges, excluding deliveries, with surgery by sex: Oahu and United States.



* From National Center for Health Statistics. Report No. 30, Series 10.

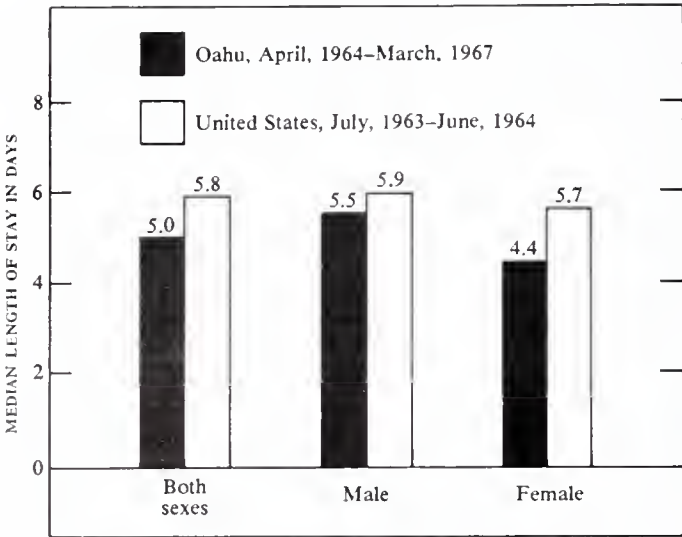
quently performed operative procedure—more than 44,000 cases during the three-year period—and constituted somewhat more than one-third of all operations. Operations on some part of the musculoskeletal system, including procedures for fractures and dislocations, were second in volume and resulted in 10.3 per cent of all operations. Operations on female genital organs ranked third and constituted 9.3 per cent of the total. Table 5 gives the volume and per cent of other types of operations.

INTERVAL OF HOSPITAL STAY

Slightly more than nine per cent of all discharges were classified as “one-day patients,” i.e., they were admitted one day and discharged the next. About three-fourths (76.1 per cent) stayed no longer than seven days and only 10.1 per cent stayed as long as 15 or more days (Table 6).

Chart 5 shows the median interval of stay by sex and age. This interval increased markedly with age and within each age group it was somewhat greater for males than females. The median number of days for all ages together was 5.6 for

CHART 6.—Median length of hospital stay in days by sex: Oahu and United States.



Note: Data in this chart were derived from health interviews only without decedent data. Also, the data do not include deliveries. U.S. data were calculated from Report No. 30, Series 10, National Center for Health Statistics.

males and 4.3 for females. Excluding deliveries, the median for females became somewhat greater, 4.6 days. The median length of stay for delivery cases alone was 4.2 days.

Chart 6 compares the median interval of hospital stay on Oahu and the United States as a whole. Since the data are based on health interviews only without decedent data, the medians for Oahu are slightly different from those shown in Chart 5 and cited above. Moreover, the data in Chart 6 exclude deliveries.

Considering both sexes together, the median interval was 5.0 days on Oahu and 5.8 in the country at large. Although the Oahu median was lower for both males and females separately, the difference was most pronounced for females.

SUMMARY

During the period of the study about 66,500 Oahu residents annually were short-stay hospital discharges. This was a rate of 116.6 per 1,000 population. A comparable rate for the country as a whole appears about 15 per cent higher.

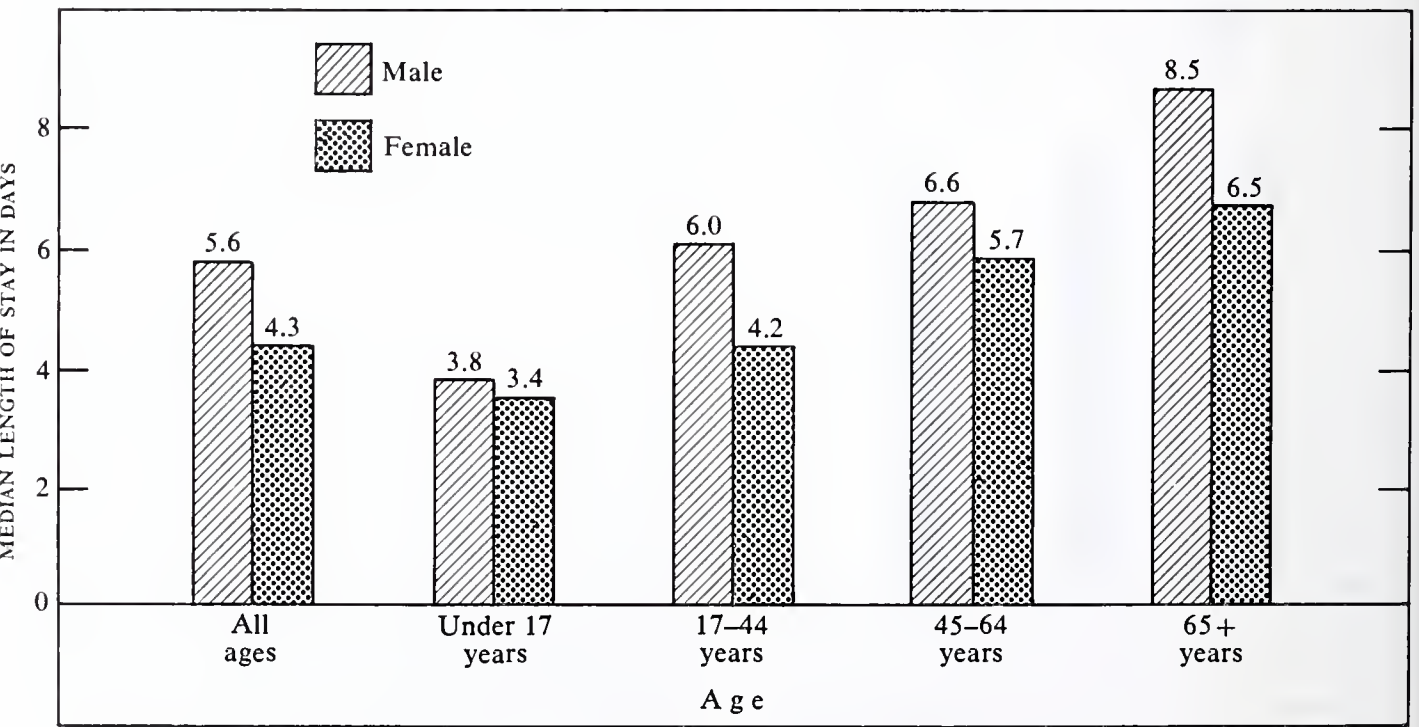
Of the major ethnic groups on Oahu, Caucasians had the highest discharge rate and Japanese the lowest. As percentages of all discharges, Caucasians ranked first followed by Japanese, part-Hawaiian, Filipino, and Chinese—in that order.

The major cause of hospitalization on Oahu was delivery of mothers. This accounted for 22.2 per cent of all discharges. In short-stay hospitals of the country as a whole, delivery cases were only about 15 per cent of all discharges.

The leading cause of hospitalization of young people under 17 years on Oahu was respiratory conditions. Among those 45 and over, diseases of the heart constituted the leading cause.

About 39,500 Oahu patients annually had surgery during hospitalization. This number was 59.4 per cent of all discharges. Excluding deliveries, the percentage of cases with surgery was

CHART 5.—Median length of hospital stay in days by age and sex: Oahu, April, 1964–March, 1967.



only slightly higher on Oahu than in the country as a whole.

Three-fourths of all discharges were hospitalized one week or less. The median interval of hospital stay for males was 5.6 days and for females, excluding deliveries, 4.6 days. The median length of stay for delivery cases was 4.2 days. The median interval of hospital stay was somewhat shorter on Oahu than in the country as a whole. ■

TABLE 6.—*Estimated Average Annual Number of Short-Stay Hospital Discharges and Percentage Distribution by Length of Hospital Stay; Oahu, April, 1964–March, 1967*

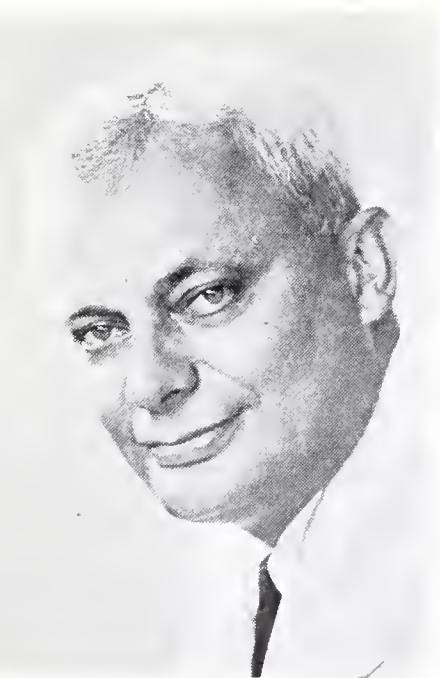
LENGTH OF STAY IN HOSPITAL	NUMBER	PER CENT
All discharges	66,500	100.0
1 day	6,100	9.2
2–3 days	21,300	32.2
4–5 days	16,000	24.0
6–7 days	7,100	10.7
8–14 days	9,200	13.8
15+ days	6,800	10.1

TABLE 5.—*Estimated Average Annual Number of Surgical Operations on Short-Stay Hospital Discharges and Percentage Distribution by Type of Operation and Sex: Oahu, April, 1964–March, 1967.*

TYPE OF OPERATION	AVERAGE ANNUAL NUMBER OF OPERATIONS			PERCENTAGE DISTRIBUTION			
	Both sexes	Male	Female	Both sexes	Male	Female	
						Including deliveries	Excluding deliveries
Total operations	42,300	14,100	28,200	100.0	100.0	100.0	100.0
Operation on the brain and skull	300	300	*	0.7	1.8	*	*
Other operation on the nervous system (except eye and ear)	400	100	200	0.9	1.0	0.8	1.6
Operation on the eye	1,300	600	700	3.1	4.4	2.5	5.2
Operation on ear and/or mastoid process	700	300	300	1.7	2.5	1.2	2.6
Operation on varicose veins	400	200	200	0.9	1.5	0.6	1.3
Tonsillectomy and/or adenoidectomy	2,700	1,200	1,400	6.3	8.7	5.1	10.8
Operation on throat, pharynx, tonsils, nose, nasopharynx, sinus, NEC	1,200	800	400	2.8	5.4	1.6	3.3
Operation for ulcer of stomach, duodenum, or jejunum	500	400	100	1.3	3.1	0.3	0.7
Other operation on stomach, duodenum, or jejunum	400	200	200	1.0	1.4	0.7	1.5
Operation for appendicitis	1,400	900	500	3.2	6.2	1.7	3.6
Repair of hernia	1,100	1,100	*	2.7	8.1	*	*
Operation on intestine, NEC	500	400	100	1.1	2.6	0.4	0.8
Operation for hemorrhoids	800	700	200	2.0	4.7	0.6	1.3
Operation on gallbladder or gall ducts	500	200	400	1.2	1.1	1.3	2.7
Other operation on digestive system and abdominal regions, NEC	1,400	700	800	3.4	4.7	2.8	5.8
Operation on kidney	300	200	100	0.8	1.4	0.5	1.0
Operation on bladder	400	300	200	1.0	2.0	0.5	1.1
Operation on prostate gland or for any prostate condition	500	500	*	1.2	3.7	*	*
Other operation on male genital organs	500	500	*	1.2	3.6	*	*
Operation on female breast	900	*	900	2.2	*	3.3	6.8
Hysterectomy	800	*	800	2.0	*	2.9	6.2
D and C (dilatation and curettage)	1,700	*	1,700	3.9	*	5.9	12.5
Other operations on female genital organs	1,400	*	1,400	3.4	*	5.1	10.6
Operation on skin and subcutaneous tissue, NEC	900	800	100	2.2	5.7	0.5	1.0
For fractures and dislocations	1,000	700	300	2.4	5.0	1.1	2.3
Other operation on musculoskeletal system, NEC	3,300	2,000	1,300	7.9	14.4	4.6	9.7
Caesarean delivery	900	*	900	2.1	*	3.1	*
All other deliveries	13,900	*	13,900	32.8	*	49.3	*
All other operations	2,000	1,000	1,000	4.6	7.0	3.4	7.2

* No cases or too few to meet standards of precision.

Note: Numbers of patients above are rounded to the nearest 100; consequently, they do not always add up exactly to totals. NEC signifies "not elsewhere classified."



The President's Page



The Hawaii Medical Association is now embarked on its 114th year of service to the citizens and physicians of Hawaii.

Never in past years have the doctors of this Association been called upon to accept the challenges and changes being demanded of us by government and society. It is obvious to all of us who have laid down our rose-colored glasses that the health care industry is in the midst of a revolution. We here in Hawaii enjoy no exception. We are in the mainstream of this demand for change.

- There is demand for change and control in manufacturing, packaging, distributing, and costing of drugs.
- There is demand for change in the patterns of delivery of health care.
- There is demand for change in the quality and equality of distribution of health care.
- There is demand for change in patterns of accessibility of available health care.
- There is demand for radical change in the cost of health care.
- There is demand for more personal review of utilization of care and quality.
- There is demand for the use of more paramedical personnel to assume some of the responsibilities that historically have always been within the purview of a medical doctor.

We must respond to the challenge with perspective, vigor, and expertise. We cannot respond with ridicule, resistance, and small thoughts.

The degree to which organized medicine becomes involved in the above will determine to what extent we as physicians will chart our destiny. We must force ourselves into the mainstream of this change individually and collectively as members of this organization.

We must be vigilant, innovative, and amenable to change. We must not allow anyone—especially government—to divert us from our primary purpose of ministering to our patients.

This year will be exciting and productive. There has never been a time when it has been so necessary for the physicians of Hawaii to close ranks and approach these challenges together.

George H. Mills M.D.

"Cure" of Heroin Addiction

Over 15 heroin addicts in Hawaii have been cured of their addiction to heroin, and over a dozen of them are employed now on a regular basis—an activity they could never afford before, since they needed anywhere from \$100 to \$1,000 a day to buy the heroin they had to have, and no jobs were available at such salary levels. Only prostitution, shoplifting, or robbery could provide for such needs.

These addicts have been cured by fighting fire with fire—by fighting narcotic addiction with addiction to another, different narcotic, one which is harmless, produces no wild swings from "high" to "sick" levels, costs only about 25¢ a day, and makes them immune to heroin, as well as eliminating any need or desire for it. The narcotic they take is methadone (Dolophine). They take it orally every day at the Queen Emma Clinic, under the supervision of Dr. Charles W. Stewart, Jr. and their urine is taken three times a week to be tested for drugs.

Methadone is a class A narcotic, a potent analgesic, known for over 20 years but used to "block" the effects of heroin only since about 1964. It is about as potent as morphine, but much more effective orally. An oral dose of 22 mg is as effective as 10 mg intramuscularly.¹ A therapeutic dose is 10 mg by mouth or 2.5 mg by hypo.

Dole and Nyswander^{2, 3} have reported their results with its use in the management of heroin addiction. The results are impressive—88% cures in over 900 addicts, to date.⁴ Addicts are hospitalized and given 5 to 10 mg of methadone orally twice a day for one or two weeks; then either the morning or the evening dose is increased by 5 to 10 mg every four to seven days, until 40 to 50 mg twice a day is being taken. Then a gradual shift is made to a single morning dose, which must be taken indefinitely, just as a severe diabetic must take insulin indefinitely. The FDA hasn't gotten around to authorizing this use of methadone yet. An article in the current *New England Journal of Medicine* may help them to get started in this direction.⁵

It is surprising that patients are hardly ever lost from this program through their own defection

from it, or through physical intolerance for the medication. What is downright astonishing, however, is the high rate of successful rehabilitation of these supposedly inferior individuals. Among the group treated by Dole and Nyswander, three-fourths of the addicts have become normal, socially productive citizens within six months of starting the treatment. This spectacularly high rate of successful restoration to normal behavior is causing the experts to take a new look at our theories of the cause of drug addiction. Addicts are thieves and liars, to be sure, but was this character defect the reason they became addicted, or was the addiction the cause of the character defect? It begins to look as if the truth lay nearer to the latter than the former.

At any rate, the John Howard Association, through its program director, Andy Lyons, has pioneered this method of treating heroin addiction in Hawaii. Though the cost of medication is small, only about 25¢ a day, the patients are charged, for their own good and to support the program, \$10.00 out of the total cost of \$14.00 a week. Addicts, accustomed to paying \$70.00 to \$7,000 a week, do not find this unreasonable. The John Howard Association absorbs the difference.

The goal of the program is twofold—to get every known addict in Hawaii off his heroin or morphine and reintegrated into society as a productive citizen, and to find out as much as possible about what distinguishes addicts, on or off their narcotic, from nonaddicts, what causes addiction, and to what extent various supportive measures, in addition to the methadone, must be given credit for the successful results.

REFERENCES

1. Beaver, W. T., Wallenstein, S. L., Houde, R. W., and Rogers, A.: A clinical comparison of the analgesic effects of methadone and morphine administered intramuscularly, and of orally and parenterally administered methadone, *Clin. Pharmacol. Ther.* 8:415 (May-June) 1967.
2. Dole, V. P., Nyswander, M. E., and Kreek, M. J.: Narcotic blockade, *Arch. Intern. Med.* 118:304 (Oct.) 1966.
3. Dole, V. P., and Nyswander, M. E.: Heroin addiction—a metabolic I disease, *Arch. Intern. Med.* 120:19 (July) 1967.
4. Lyons, Andy: Personal communication.
5. Dole, V. P., Robinson, J. W., Orraca, J., Towans, E., Searcy, P., and Caine, E.: Methadone treatment of randomly selected criminal addicts, *New Eng. J. Med.* 280:1372 (June 19) 1969.

Don't Drop Out, Doctor!

Most young doctors ally themselves with organized medicine by joining their county medical society and the AMA shortly after they obtain their license to practice, and pay dues annually up to the time of their retirement, when dues are waived. Probably half of them rarely if ever attend a meeting, let alone serve on a committee—but they do pay their dues.

A few doctors become dropouts along the way, often because the dues or assessments seem to loom too large, though this is seldom admitted. More often, disillusionment with national or local leadership is professed. Frequently, in such cases, one notes a disparity between their expectations and their achievement. But what they say is that they “see no reason for supporting organized medicine.”

We think there are plenty of excellent reasons for supporting organized medicine. Maybe they could stand a little reiteration. Doctors working together can perform many services for one another, and for the community, that they could not accomplish individually.

The Medical Practice Committee provides peer review for, and consumer protection against, questionable professional practices—the only acceptable alternative to their correction by legislative fiat. And it can be a great help in cases where malpractice litigation is threatened, furnishing professional counsel and legal advice as well.

Fec schedule committees provide the only possible means of negotiating equitable fees, and periodic adjustments of them, to be paid by “third parties.” Individual doctors could never deal one by one with RMP, OEO, Model Cities, Medicare, OCHAMPUS, Medicaid, and so on—let alone local agencies like HMSA and the Workmen's Compensation Commission. Things are bad enough, but they might be worse!

Professional education is promoted by the medical society through maintenance of our library, publication of our JOURNAL, visiting lecturers, and in other ways. It has been complained that our monthly meetings in Honolulu do not have scientific programs; but so many members now specialize, either in general practice or something narrower, that it is hard to find attractive topics. And speaking of specialists, Specialty Boards all require medical society membership.

Direct personal services to members of the medical society are provided by the emergency call service, by the medical assistants' training pro-

gram, by counselling on the conduct of medical practice when requested, and by provision of group disability insurance.

So much for what you *get* out of membership—though we have not exhausted the catalogue yet. What does membership enable you to *give*?

It enables you to support school health programs; the Lions Club blindness program; diabetes detection surveys; disaster planning; community-wide vaccination programs; and planning for rural health services such as those at Waianae, Nanakuli, and in the Waikiki Jungle.

It lets you support, and participate in, medical enlightenment for your community, through the Health Fair; through the TV series, “Medically Speaking . . .” now in its ninth year; through studies of absenteeism in industry; through Carcers Day to enlighten and encourage potential medical students; and in other ways.

Planning for the future shape of medical practice, considering such possibilities as prepayment plans, education and even licensure for specialties, periodic relicensing, and others, can be done by our profession for ourselves, unless we'd rather sit back and let someone do it for us.

In addition to all these local programs, and more, there are countless valuable services performed for individual members and for the public at the national level by the AMA, which deserve the support of every thoughtful physician. They are too numerous even to list here. If you're skeptical, please ask for a folder; it will open your eyes!

The fact is that a physician who practices his profession but remains outside his county, state, and national medical organizations is only part of a doctor, not a whole one. Sir William Osler, that great physician and master of the trenchant phrase, had one for such physicians. “They are,” said he, “medical drones, whose sole interest in their profession is a pecuniary one.”

Paul Bunyan, legendary hero of the American logging camps, said he didn't care if the guy on the other end of his crosscut saw rode on his end of the saw. He just didn't want him, he said, to drag his feet. Well, a doctor who isn't at least maintaining his membership in his medical society *is* dragging his feet.

And that about sums it up. We sincerely hope—if this *does* apply to you—that you'll have second thoughts about it, and give us cause to rejoice at your readmission to the fold! ■

"Fly the Friendly Skies"

We have been impressed by the number of visitors to Hawaii who sustain pulmonary emboli within a few days of arrival. A common story is of the sudden onset of dyspnea, associated in a few cases with evanescent chest pain and hemoptysis. Physical examination often reveals little except rapid respiration and sometimes tachycardia. The demonstration of obvious peripheral venous thrombosis is uncommon. Clinical suspicion must be confirmed by radioisotope lung scan, supplemented in some cases by venography, which may demonstrate silent and unsuspected thrombosis of the deep leg veins.

The majority of those stricken travel here by air, which seems to predispose to the development of venous thrombosis. That prolonged travel in commercial jet aircraft does affect vascular dynamics can be easily demonstrated. The next time you fly to the mainland, remove your shoes just after takeoff, and then try putting them on again at your destination! More scientific explanations must be conjectural, but an important factor must be prolonged sitting and immobility, leading to venous stasis in the lower limbs. Concomitant conditions which increase platelet adhesiveness, and thereby predispose to thrombus formation, are adrenalin release and smoking. The effects of cabin pressurization, and acceleration or deceleration changes during landing and takeoff, are perhaps more subtle but probably are also etiologically significant.

Treatment is with anticoagulants, bedrest, and careful observation in some type of acute care facility, such as the ICU or CCU. If embolization continues despite adequate anticoagulation, urgent consideration must be given to inferior vena caval interruption by plication or ligation.

Travelers to Mexico are familiar with "*turista*," the tourists' disease. The Hawaiian variety, though less obvious in its manifestations, is potentially more serious, unless promptly recognized and vigorously treated.

Wheeze Replaces Fleas?

Weiner and Worth, in the March-April HAWAII MEDICAL JOURNAL, report a high correlation between the amount of use of insect sprays and the incidence of asthma and other respiratory problems, in individual homes. They hint at the pos-

sibility that components of these sprays may induce or aggravate respiratory symptoms in susceptible persons.

Other equally plausible explanations of this apparent association suggest themselves. For instance, some households may be sprayed more heavily because they have more insects. This larger insect population would provide a larger quantity of allergenic insect bodies, hairs, and scales to be inhaled. Such a situation would be likely to be associated with a rainier climate, and in such an area molds and pollens would be likely to be more abundant and thus contribute to the production of asthmatic symptoms in susceptible persons.

More subtle psychological factors may also be involved. Can we not consider the compulsive sprayer as a person with a great deal of repressed hostility, which he tries to act out by attacking insects? Psychiatrists agree that many asthmatics do have large amounts of repressed hostility. So the compulsive sprayer may be spraying because he is an asthmatic, rather than vice versa.

A wise man once said that "No naturally occurring phenomenon ever has a simple explanation."

Alcoholic Alkalosis

Hung over after the last party? Try carbon dioxide inhalations. That's the latest word from Dr. Sidney Wolfe of the NIH. He studied the effect of sudden alcohol withdrawal on a group of volunteers. Most developed symptoms about 12 hours after cessation of drinking, prominent features being tremor, convulsions, and hyperreflexia. Blood analysis at the time of maximum symptoms, surprisingly, showed a pure respiratory alkalosis. The similarity between the physical manifestations of alcohol withdrawal and those of acute hyperventilation, either spontaneous or deliberate, attest to the validity of this finding.

Applying this newfound knowledge, Dr. Wolfe gave carbon dioxide inhalations to two alcoholic patients during withdrawal. He found they experienced considerably milder symptoms than the others.

The sufferer awakening on the morning after might perhaps conduct his own clinical trial by breathing in and out of the large brown paper bag thoughtfully provided by the liquor store for wrapping his purchase. ■

W. PHILIP JONES, M.D.



Hawaii Academy of General Practice

... ONCE AGAIN, LIFTERS VS. LEANERS.

Of the American Medical Association, we in Hawaii are a very small part—just one delegate; about 0.5%.

One cannot become a member of the AMA without first joining state and county medical societies. It is all or none. The AMA is considered to have one of the most powerful lobbies in Congress. The AMA has a large staff of hired professionals, full-time MD's and PR people. The *JAMA* and the *AMA News* come close to being in the "throw-away mail" category.

The Hawaii Medical Association is wholly ours—we of the 800-plus physicians in the State of Hawaii. The HMA has dozens and dozens of committees. It, too, has highly paid experts, a lawyer, and a lobbyist. The HMA has a very hard time getting the large membership either to cooperate, or to participate in its projects, in what the leadership thinks we need to do for ourselves and for our State. It hopes we members at least listen, and perhaps even read. Who's to evaluate the usefulness of the HMA to the community, the State of Hawaii, or to us, its members?

For those of us on Oahu, it is the Honolulu County Medical Society that represents the "grass roots" level of concerted social effort in medicine. It too has a large budget, in support of which heavy dues are imposed upon us. Many think it has its wheels spinning aimlessly, a thought ascribed to the AMA and the HMA as well, that there is duplication of effort with HMA. Others believe that the "dog" (HCMS) is being wagged by the "tail" (the other county medical societies) in our efforts for the HCMS *not* to be synonymous with HMA. There is no escaping the fact that the HCMS is growing rapidly larger; that its weight of numbers is being felt more and more, statewide.

There are not a few of us who feel that we are slaves to the hierarchy in organized medicine, forgetting perhaps that the benefits we now enjoy are the result of state and national action. Some of these people "want out." They would like to see the HCMS broken up into smaller units. They want more "home rule." They have a point.

Although there is strength in numbers, the larger a society is the more it loses in participation by individuals—by numbers of individuals. The large society can afford to hire professionals; the small group cannot, but it gains in voluntary effort from its smaller membership. The larger society must rely on the dedicated effort of only a few of its members, suffering the majority to become completely apathetic.

The time has come, as we grow more and more populous, for us physicians in Hawaii to reassess our purposes and goals.

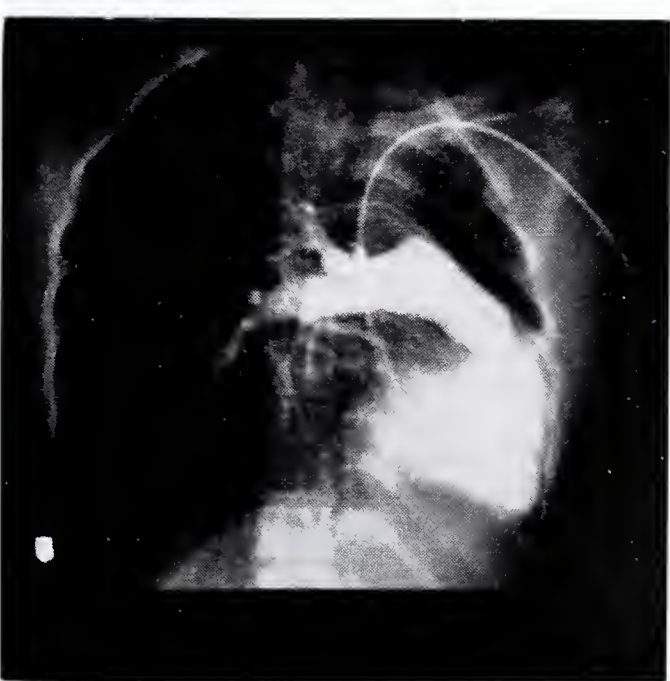
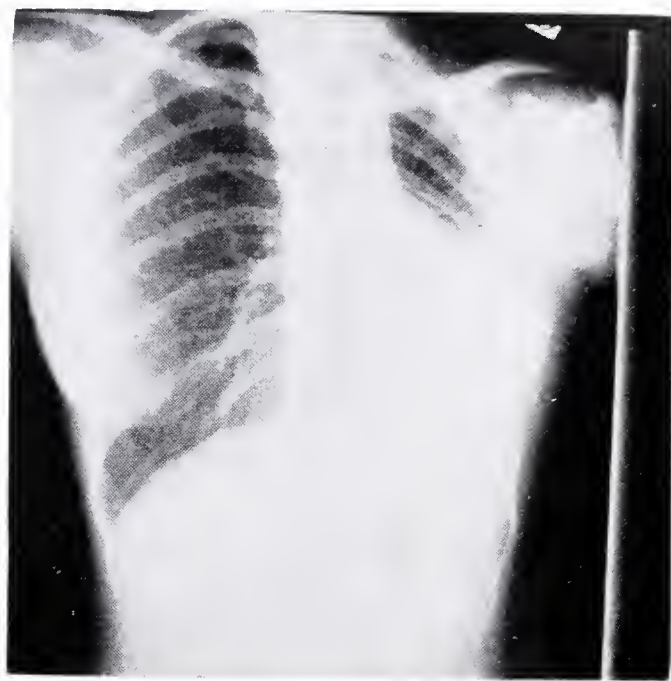
If you are a Leaner—one who selfishly is determined only to feather his own nest—just you keep on riding for free! Decent democratic societies are not likely to ever get tough on the recalcitrant member. "Lucky you no live USSR," where communism has come to mean persuasion-by-force.

If you are a Lifter, a supporter, an attender-of-meetings if not a committee member, and if you feel perhaps that our body politic has become too large, here is an opportunity for you to make your views known: This is a first call for decentralization of the HCMS. But . . . exhortations are useless if no one listens to them!

If you have read these words—if you feel any response for or against the idea—phone 247-2161, give your name and answer "Yes" or "No." (At least we'll discover who reads this printed page every two months!) ■

J. I. FREDERICK REPPUN, M.D.

- The patient is a 20-year-old Caucasian housewife with no complaints. The chest film was made as part of a routine examination. The patient had been told that at the age of three her left lung was collapsed. She had the usual childhood diseases and had a tonsillectomy in 1963, and an appendectomy in 1965. She had been able to carry on her housework without effort and engaged in high school physical education without restraint.
- Physical examination is negative except for asymmetry of the chest with the right chest more prominent and showing greater excursion on respiratory effort. Breath sounds are increased on the right as compared to the left.
- Laboratory examinations are negative. EKG suggests right ventricular hypertrophy.
- A pulmonary angiogram was done by means of dye injected into the right auricle through a catheter inserted in the left antecubital vein.



X-ray Diagnosis: There is complete absence of the left pulmonary artery and of the left lung. The lesion is congenital and in the absence of clinical symptoms, no treatment is needed.

Submitted by the
RADIOLOGICAL SOCIETY OF HAWAII
THOMAS C. BROWN, M.D.



University of Hawaii.....

All 25 of our second-year medical students have been accepted to mainland medical schools as follows: University of Arizona 1, University of California San Francisco 2, University of Colorado 9, Albert Einstein 1, Emory 1, Harvard 2, Minnesota 1, Mount Sinai New York 2, Northwestern 1, University of Pennsylvania 1, Stanford 1, Tulane 1, University of Washington 2. Seven other medical schools (Bowman Gray, Boston University, State University of New York at Buffalo, Creighton, Ohio State, Tufts, and Washington University St. Louis) accepted students who instead chose one of the schools listed above. The students are pleased with their choices and the faculty is well satisfied with the types of school in which our students will finish their preliminary medical education.

Twenty medical students are taking summer fellowships in the Honolulu area as follows: Community medicine (under the direction of **Fred I. Gilbert, Jr., M.D.**, and the guidance of **Daniel Bessesen** at Waianae-Nanakuli) **Frank Yamamoto**; neuroepidemiology (under the direction of **Michael M. Okilhiro, M.D.**) **Thomas Morris**. These two fellowships in community health have been funded by the Straub Medical Research Institute. Summer fellowships in psychiatry (under the direction of **John McDermott, M.D.**, **Walter Char, M.D.**, **Leigh Sakamaki, M.D.**, **Y. Hokama, M.D.**, **Charles Stewart, M.D.**, **N. Rock, M.D.**, and **Don Char, M.D.**) will be taken by two first-year students, **Fred Fong** and **Joan Watson**, and by six second-year students, **David Monahan**, **Wally Chun**, **Steven Kreitzer**, **John Tkach**, **Don Jensen**, and **Jeff McDevitt**. Clinical cancer summer fellowships at the Tripler General Hospital Department of Medicine will be taken by students **George Chu**, **John Nelson**, and **Daniel Chuba**, in Obstetrics-Gynecology by **Robert Watson**, and in oncology **Rolland Nakashima** and **Dennis Murakami**. Cancer fellowships at the Children's Hospital will be taken by **Roy Wong**; clinical cancer fellowships in radiology will be given (at the Queen's Medical Center under the direction of **Grover Liese, M.D.**, St. Francis Hospital, **Richard Moore, M.D.**, and the Straub Clinic, **Robert Rigler, M.D.**) for students **Eugene Kawachi**, **Norbert Wong**, and **Roland Tam**.

Kenneth D. Gardner, M.D., previously of Stanford University, has been appointed Profes-

sor of Medicine at the University of Hawaii School of Medicine and will have his office at the Leahi Hospital. Dr. Gardner's interest is in nephrology and he will also be student advisor and coordinator for the student fellowship summer program.

Harry C. Shirkey, M.D., Chief of the Section of Pediatrics, delivered the Aaron Brown Memorial lecture at the University of Cincinnati Medical Center on the 14th of May. The lecture was entitled "Therapeutic Orphans: Pediatric Pharmacology." While Dr. Shirkey was in Cincinnati he also spoke to the medical students on "Problems of the Use of Drugs in Children," and at the Children's Hospital Research Foundation "The Drug Efficacy Study of the National Research Council of the National Academy of Science."

In the Section of Obstetrics and Gynecology, **Robert Noyes, M.D.**, accompanied by family planning physicians from American Samoa, Tonga, Western Samoa, Guam, Fiji, Saipan, Papua, and Tarawa visited the Chinese Center for International Training in Family Planning in Taichung, Taiwan, Republic of China, May 18-31, 1969. The Chinese are offering assistance by way of personnel and material to the countries of the Pacific Basin to help them solve their population problems.

After two years as Director of the University of Hawaii School of Medicine's Postgraduate Medical Education Program at the Central Hospital, Okinawa, **Neal Gault, M.D.**, has returned to the Leahi Hospital where he will teach in the Department of Medicine and assist Dean Cutting in planning the future development of the School of Medicine.

Richard Mamiya, M.D., Chief of Surgery, attended the 49th Annual Meeting of the American Association for Thoracic Surgery March 31 to April 2, 1969 in San Francisco.

The University of Hawaii School of Nursing's Department of Dental Hygiene has arranged with the Concentrated Employment Section of the Model Cities Program in Kalihi, Palama, and Waianae-Nanakuli to have the enrollees participate in their Clinical Training Program. This is in coordination with the State Department of Health's Dental Hygiene Section. Patients from the Children and Youth Program at Waimanalo will also be included. ■

ROBERT W. NOYES, M.D.

This is the seventy-ninth installment of In Memoriam—Doctors of Hawaii.

Nathaniel Morrel Benyas

Nathaniel Morrel Benyas was born in Negaunee, Michigan, on July 3, 1887. He attended Negaunee High School, graduating in 1903, and his medical degree was granted by Northwestern University in 1912.



DR. BENYAS

On May 20, 1913, Dr. Benyas married Dorothy Reeder in Philadelphia. They had two children, Naomi June (Mrs. Richard Pollard) and Eugene Casselberry.

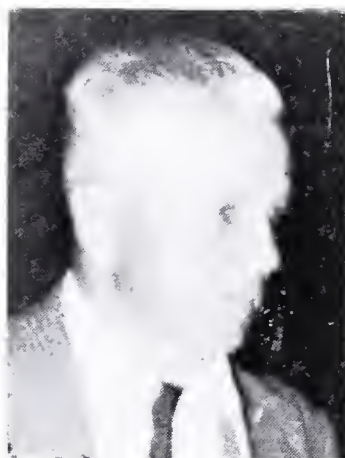
Dr. Benyas entered private practice in Portland, Oregon, in January, 1914, where he remained until September, 1917, when he entered the Army Medical Corps. He saw service as a lieutenant, captain, and major, and went overseas with the 91st Division of the First Army Corps. Following the armistice, he entered Germany with the Army of Occupation.

Leaving the Army on August 25, 1920, Dr. Benyas came to Hawaii to establish a home and enter private practice. He served as Medical Director of the Territorial Board of Health from July 1, 1921, to June 30, 1929. From January 1, 1922, to April 11, 1928, he was Medical Director of Palama Settlement. For many years he was the official physician for the Territorial Boxing Commission. In 1929 he served as general secretary of the Pan-Pacific Surgical Congress. During some 18 years (1921-1939) he held the rank of major in the Medical Corps of the Hawaii National Guard.

He was a member of the American Medical Association, the American Medical Association of Vienna, the Territorial Medical Association, the Honolulu County Medical Society (president in 1943), Northwestern University Alumni Association, the Rotary Club, and was a Scottish Rite Mason, a Shriner, and an Elk.

Adolph George Schnack

Adolph George Schnack was born in Honolulu on September 23, 1887, the son of John Henry and Doris (Brandt) Schnack.



DR. SCHNACK

He graduated from Punahou in 1906, and received his B.A. from Stanford in 1910, his M.A. from Yale in 1911, and his M.D. from Johns Hopkins School of Medicine in 1915. Dr. Schnack interned at Massachusetts General Hospital in Boston from 1915 to 1916 and served at

Boston Infants' Hospital for four months from 1916 to 1917.

On October 17, 1917, Dr. Schnack married Miss Adele Field Sherman at Cambridge, Massachusetts. They had two sons, Theodore Sherman and Robert Sherman, who died at the age of four.

At the completion of his hospital work, he served with the U.S. Army Medical Corps until April, 1920, when he returned to Honolulu and opened an office for the practice of diagnostic medicine and roentgenology. At various times during the next 28 years Dr. Schnack was associated with Queen's, Shriners', St. Francis, and Kuakini hospitals as roentgenologist. Retiring from active practice in 1948, he left the Islands and settled in Riverside, California.

On February 19, 1964, Dr. Schnack died in Riverside at the age of 76.

He was a diplomate of the National Board of Medical Examiners, a fellow of the American College of Physicians, a fellow of the American College of Radiology, a member of the Honolulu Medical Society, the Hawaii Medical Association, and the American Medical Association.

While in Honolulu the doctor had a stable of thoroughbred racing horses and was interested in racing. ■

COUNCIL MEETING

**May 15, 1969—6:30 p.m.
Oahu Country Club**

PRESENT

Robert M. Miyamoto, presiding, Drs. Batten, Chinn, Fong, Iaconetti, Jones, Lowrey, Mills, Miyashiro, Richardson, and Sloan, plus Drs. G. Goto, R. Chung, J. Oren, K. S. Tom, T. Tomita, and Mr. H. Tom Thorson.

MINUTES

The minutes of the April 23, 1969, meeting were approved as circulated.

REQUEST OF MR. V. THOMAS RICE

At the last meeting the Council voted "to approve travel expenses for the legal counsel to Hilo, Hawaii, and that counsel should be present when the House of Delegates convenes on Wednesday, May 21, at 1:00 P.M. and stay until the time the House of Delegates ends its deliberations."

Mr. Rice requested that consideration be given to modifying this action to provide for attendance at the second day of the meeting only. In the past Mr. Rice's services have not been required on the day the reference committees meet. Mr. Rice stated it would be an extra expense to the Medical Association and he would appreciate being relieved of the necessity of appearing on the first day of the meeting.

ACTION:

It was voted to accept Mr. Rice's request.

CLARIFICATION OF RMP APPOINTMENTS

The secretary noted that this letter was written because of the closeness of the last Council meeting to the HMA Annual Meeting and as noted in the letter the current president-elect is already on the Executive Committee and there is no other president-elect until May 23. At the time of the discussion at the last Council Meeting, it was requested that someone for this position be designated to provide continuity. The secretary questioned if it is the intent of the Council that the request to appoint the president-elect be made after the May 23 election. It was pointed out that the RMP Executive Committee, at the present time, is made up of seven members, three of which are physicians. It was suggested that a letter be written to Mr. Richard Davi, Chairman of the Executive Committee, stating that the HMA representative to the Executive Committee will be the HMA president-elect.

ACTION:

It was voted that the president-elect of the HMA be the appointee to the RMP Executive Committee each year, and that this appointment be submitted to the RMP after the annual meeting of the HMA.

With regard to the appointment of three additional members to the Regional Advisory Group, appointments to this body are for a period of two years. The current appointments became official when RMP went operational September 1, 1968. Initially, the appointments to RAG were made by the Governor. However, the secretary stated that there is no approved protocol for accomplishing this at the present time.

Dr. Richard Moore pointed out that in his RMP Report, submitted to the Council on April 23, it was recommended that the Council request the grantee institution to

appoint three representatives of the HMA to the RMP. There are two methods of doing this; either by appointment of the HMA physicians already serving on the RAG or by appointment of additional members. It was also recommended that a committee be established within the Bureau of Research and Planning and charged with the responsibility of insuring adequate communication with the designated HMA representatives to RMP.

ACTION:

It was voted to accept Dr. Moore's explanation and that it be the tenor of the Council at this time.

ANNUAL MEETING SCHEDULE

At the last Council meeting it was voted that the secretary submit some names as tentative meeting places for the projected annual meetings noted in his report. The secretary reported that dates for annual meetings on any island other than Oahu should not be set until the construction of adequate facilities is completed. In the case of Kauai, that Society voted "that Kauai be host to the HMA at such time that a Kauai member be president of the HMA. This was referred to the Executive Committee for final action and decision." When these conditions are met, a reappraisal of meeting places can be considered.

The following meeting dates and places are suggested and, if approved by the Council, will be recommended to the House of Delegates:

1970—Hilton Hawaiian Village—week of May 3-9
1971—Sheraton Meeting Hall—week of May 2-8
1972—Hilton Hawaiian Village—week of May 7-13
1973—Sheraton Meeting Hall—week of May 6-12
1974—Hilton Hawaiian Village—week of May 5-11

ACTION:

It was voted to accept the report of the secretary's annual meeting schedule and that the HMA Annual Meeting be held at the Hilton Hawaiian Village during the week of May 3-9, 1970.

It was voted that the tentative schedule for the next four years following 1970 as noted in the secretary's report be accepted at this time.

CORRESPONDENCE FROM J. I. F. REPPUN

In the correspondence received from Dr. Reppun on May 1, 1969, he suggested that "if the HMA as a body would go to the Legislature and offer, for a set fee of x million dollars, to provide the entire package of medical care for a specified total number of welfare clients per annum, this fee not to be changed except on the basis of enrollment from year to year, for a specified number of years such as five or ten, the legislators might well jump at the proposition. For the State it would mean converting the headache into a truly budgetable item. The HMA could then farm out through subrogation on the basis of insurance, hospitalization, medication, and perhaps even transportation and subsidization of certain physicians if necessary. Every member of HMA might agree to charge these patients nothing and to be reimbursed from the Fund a stipulated amount to cover overhead, as determined. There might be a system of distribution or rotation to spread the load, or at least make it worthwhile for some to participate. That which is saved from the annual expenditures through this discounting by and for ourselves, can then be invested, etc., the accumulating proceeds then to benefit all member physicians or even the participating physicians in retirement or otherwise. We would have the incentive as in private practice; we

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★**Progress in Gastroenterology, Vol. I**

Edited by George B. Jerzy Glass, M.D., 520 pp., \$29.50, Grune & Stratton, 1968.

THIS NICELY BALANCED BOOK combines newer experimental work, physiology, and some down-to-earth advice in patient management in its 20 chapters. The authors emphasize the necessity for biopsy of patients with gastritis to be sure of the type of problem with which you are actually dealing. Another uncommon facet, of which people don't very often think, is the high-output failure which frequently complicates gastrointestinal hemorrhage in patients with cirrhosis.

A practical point is brought out by Dr. Peter Holt of St. Luke's Center in New York: the value of medium-chain triglycerides in therapy of poor or absent bile secretion. This has proved to be quite a lifesaving product. It's also very helpful in patients with pancreatic insufficiency or chylous ascites.

W. Trevor Cook of Birmingham, England discusses adult celiac disease; he points out that lactase deficiency may be associated and explains why the patient does not respond to gluten withdrawal. He also brings out a little-known fact: fatal neuropathy, responsive to no treatment at all, occurs in a small percentage of these patients, and occasionally their illness terminates in a lymphoma.

The section on differentiating granulomatous colitis and ileocolitis from idiopathic ulcerative colitis is presented by Dr. Marshak, a gastroenterologist from Mt. Sinai Hospital in New York. The illustrations are very pretty and help a great deal.

On the discussion on pancreatitis, its diagnosis and management, they turn to Drs. Mark, Spank, and Louw of Capetown, So. Africa, who presented a slightly different perspective from the American authors. They distill it down to pancreatitis secondary to chronic biliary disease or to chronic alcoholism or both, and present a very interesting form of therapy.

The last chapter gives a nice pictorial review and discussion of the use of angiography in the diseases of the gastrointestinal tract, a topic which has become rather important in view of the advances in vascular surgery in people with obstructive disease of the mesenteric and celiac vessels.

This book will bring you up to date on what's going on in gastroenterology, from both the practical and the basic science point of view.

RAYMOND M. DEHAY, M.D.

Treatment of Hemorrhagic Disorders

Edited by Oscar D. Ratnoff, M.D., with 15 authors, 242 pp., \$8.50, Harper & Row, 1968.

THIS SMALL VOLUME is concerned primarily with the clinical treatment of hemorrhagic diseases, written by 15 different individuals of various specialties (hematology, psychiatry, dentistry, obstetrics, and genetics). The book is divided essentially into two parts: the treatment of the congenital, and of acquired, hemorrhagic disorders. Genetic counselling is discussed in one section. This little volume is essentially the clinical approach to the treatment of bleeding defects. It is brief, clear, and concise. It is of value to anyone having to treat and care for patients with bleeding disorders.

ROBERT T. S. JIM, M.D.

★ means highly recommended.

Female Hormones and Woman's Health

By Lyle Bachman, M.D., 145 pp., \$2.85, Mid-Pacific Press, 1968.

THE WRITING is rather whimsical and very biased in its outlook. Much of the material is not based on good, recognized scientific authority, but rather reflects the author's prejudiced viewpoints. This reviewer does not believe this publication is up to the ordinary minimum standards for what such publications should be.

This is a very critical comment on this man's writings, but I feel many of the statements are not backed up by good scientific or clinical observations as reported by most authorities in this field.

CHARLES A. HUNTER, M.D.

Synopsis of Pathology, 7th Ed.

By W. A. D. Anderson, M.D., and Thomas M. Scotti, M.D., \$10.50, The C. V. Mosby Company, 1968.

THE LATEST EDITION of the well-known "baby Anderson" has been updated and revised while retaining its original format. A new chapter on ultrastructure, cytogenetics, and inheritance has been added. The clinical and pathological features, both gross and microscopic, of a large variety of disease entities are concisely presented, and are supplemented by black and white photographs of reasonably good quality.

It is not the authors' intent that this volume should be used as a textbook, but rather as a review and refresher for clinicians, and as an aid to students and workers in the paramedical fields. It succeeds in its purpose, and would be a useful addition to any clinician's library.

ANN B. CATTS, M.D.

★**Synopsis of Surgery**

By Richard D. Liechty, M.D., and Robert T. Soper, M.D., 1,091 pp., \$12.50, The C. V. Mosby Company, 1968.

THIS EXCELLENT MANUAL achieves its objective in teaching the essentials of surgery. The authors and other faculty members of the University of Iowa College of Medicine have organized the entire field of surgery in a thorough and easily readable manner. The first chapter deals with the origin of surgical disease; the second with wounds, wound healing, and drains; the third with fluids and electrolytes; the fourth with blood coagulation and transfusion; the fifth with shock; the sixth with surgical infections; the seventh with nutritional care of patients; the eighth with preoperative care; the ninth with anesthesia; and the tenth chapter with postoperative care. These ten chapters on basic principles of surgery pertain to subjects shared by all physicians. The chapters are well written and are replete with useful tables and illustrations. The remaining chapters of the manual cover the spectrum of surgery either by organ systems or by specific specialties. They cover the pathophysiology of disease in its broadest fashion and relate preclinical principles to surgical problems by excellent illustrations and diagrams.

The diagnosis, laboratory examinations, and treatment are described, although surgical procedures are purposely not dealt with in detail. However, the basic principles and use of necessary tools in emergency care of the severely injured, in cardiopulmonary resuscitation, in con-

continued page 541



Eldon Edgar Smith, M.D.

Queen's Medical Center
Honolulu, Hawaii 96813

ANESTHESIOLOGY

University of Louisville—1939

Internship—Springfield (Ohio)

General Hospital—1939-1940

Residency—Leila Y. Post Montgomery
Hospital—1940-1941



Harry Cameron Shirkey, M.D.

Kauikeolani Children's Hospital
226 No. Kuakini Street
Honolulu, Hawaii 96817

PEDIATRICS

University of Cincinnati—1945

Internship—Cincinnati General
Hospital—1945-1946

Residency—Children's Hospital and
Cincinnati General Hospital—
1948-1950



Abe Oyamada, M.D.

1010 So. King Street, Room 2
Honolulu, Hawaii 96814

PATHOLOGY

University of Oregon Medical School
—1947

Internship—Broadlawns Polk County
Hospital, Des Moines, Iowa—
1947-1948

Residency—Mt. Sinai Hospital of
Chicago—1948-1952



R. Reginald Patterson, M.D.

Leeward Clinic
Aiea, Hawaii 96701

GENERAL SURGERY

Queen's University, Kingston,
Ontario, Canada—1936

Internship—St. John General Hospital,
St. John, N.B., Canada—1936-1937

Residency—St. Vincent's Hospital,
Birmingham, Alabama—1938-1939



Arnold W. Siemsen, M.D.

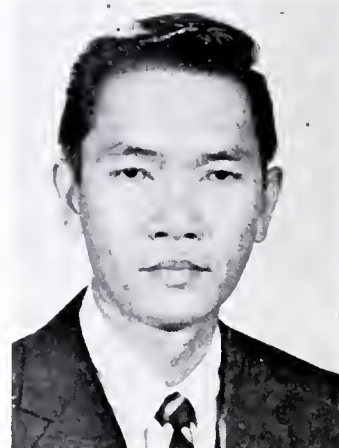
888 So. King Street
Honolulu, Hawaii 96813

INTERNAL MEDICINE

Nebraska Medical School—1956

Internship—Bishop Clarkson,
Omaha, Nebraska—1956-1957

Residency—Brooke General Hospital
San Antonio, Texas—1960-1963



Ruben P. Mallari, M.D.

91-1841 Ft. Weaver Road
Ewa Beach, Hawaii 96706

INTERNAL MEDICINE

University of the Philippines—1958

Internship—Church Home and
Hospital, Baltimore—1958-1959

Residency—Church Home and
Hospital—1959-1960

City Hospital, Winston-Salem—
1960-1961

Mercy Hospital, Baltimore—
1961-1963



Daniel M. Baer, M.D.

St. Francis Hospital
2260 Liliha Street
Honolulu, Hawaii 96817

PATHOLOGY

New York Medical College—1957
Internship—Stanford University
Hospital—1957-1958
Residency—V. A. Hospital,
San Francisco—1958-1961
San Francisco General Hospital—
1961-1962

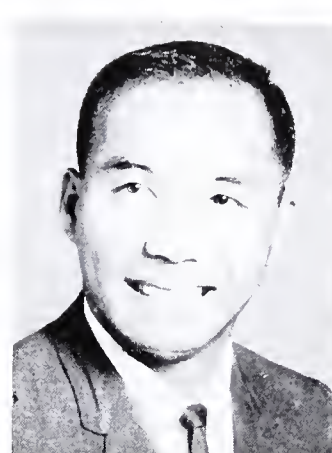


Clayton A. Johnson, M.D.

Box 218
Kaunakakai, Molokai 96748

ANESTHESIOLOGY

University of Minnesota—1964
Internship—Tripler Army Hospital—
1964-1965
Residency—Brooke General Hospital
—1965-1966



Richard P. Tesoro, M.D.

606 Kilani Avenue
Wahiawa, Hawaii 96786

GENERAL PRACTICE

University of Oregon Medical
School—1963
Internship—The Queen's Medical
Center—1963-1964
Residency—Sacramento County
Hospital—1966-1967
Queen's Medical Center—1967-1968



DeWitt Hendee Smith, M.D.

305 Wailuku Drive
Hilo, Hawaii 96720

INTERNAL MEDICINE

Columbia College of Physicians
& Surgeons—1931
Internship—Presbyterian Hospital,
New York—1931-1933
Bellevue Hospital, New York—
1933-1934

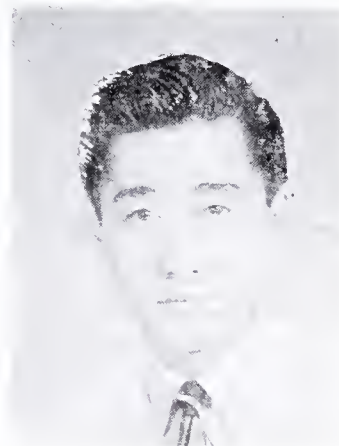


Edgar C. Davis, Jr., M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96815

RADIOLOGY

Hahnemann Medical College—1944
Internship—Huron Road Hospital,
E. Cleveland—1944-1946
Residency—Cleveland Clinic—
1954-1957



Quintin L. Uy, M.D.

1697 Ala Moana Blvd.
Honolulu, Hawaii 96814

INTERNAL MEDICINE

University of the Philippines—1958
Internship—Sinai Hospital of
Baltimore—1958-1959
Residency—Church Home and
Hospital, Baltimore—1959-1962

Professional Notes

The medical community has been relatively stable these past few months. In June, **Edwin Adams** opened his general practice office at Varsity Medical Clinic, 1239 Wilder Ave. On the varsity front, **John McDermott, Jr.**, professor of psychiatry at the U. of Michigan Medical Center, became professor of psychiatry with the U. of H. Medical School and chief of a new three-way psychiatric training program coordinated with the State Hospital, Queen's Medical Center, and the University.

We are sorry to see **Verne Waite** leave the islands after 23 years of private practice. He will join the new University of Nevada Medical School faculty and become chief of the department of surgery of its affiliate, U.S. Veterans Administration Medical Center in Reno, effective July 15. Besides his active practice, Verne has been clinical professor of surgery at U. of H. Medical School, chairman of the board of the Pan Pacific Surgical Association from 1963-66, chief of the department of general surgery at Queen's for the past three years, and part-time medical director for HMSA since 1963.

Elected, Appointed, and Honored

We congratulate **George Mills**, who was elected HMA president, and his fellow officers, **John Lowrey**, president-elect, **R. Varian Sloan**, secretary, and **Herb Chinn**, treasurer. George was elected delegate to the AMA and **Ted Tomita** (who has recovered from his surgeries) was named alternate delegate.

Once a year, a physician receives the A. H. Robins Community Service Award. This year at the annual meeting of the HMA, **Milton Howell**, a GP from Hana, Maui, was named "Hawaii's Physician of the Year." Besides being active in other civic and community projects, Milton is co-chairman of the Seven Sacred Pools Project Committee and trustee of Mauna Olu College and the Wananalua Church in Hana. The *Maui News* was enthusiastic in its plaudits: "Medically, he typifies the best of the finest points attributed to the family doctor, competent, compassionate, and available day or night. While he has earned the greatest respect from his fellow practitioners, he has earned the whole hearted devotion of his patients. . . . So it warmed our hearts to hear about the all-out welcome, the flower-bedecked reception, and the triumphant parade through town for Dr. Milton Howell when he came back home to Hana. The Hawaii Medical Association has only made official what Hana folks have known all along." The topical tropical magazine *Honolulu* asked Milton, "What are the rewards of your role (i.e., as a country doctor)" and he replied with typical modesty: "I think my feelings about being the only doctor in this small Hawaiian community can be expressed in a few words. Our mainland American culture could learn a great deal from these kind, generous, gentle people. They are experts at the most important pursuit in life—living happily with other people. I have learned more from them than I have taught. I have received more than I have given." (We feel that our physician image may yet improve with more the likes of Milton!)

On the academic front, **Edward Chesne** was named a Fellow of the American College of Physicians and **John Kim** was named an associate.

The Hawaii Heart Association re-elected **William Sage** president and elected **Ed Chesne** president-elect. **Alfred**

Morris was elected second vice-president. The Association honored **Alfred Morris** with its annual award for distinguished service in cardiovascular medicine and cited **Unoji Goto** for distinguished service to the association and the community.

The City Council passed a resolution on April 22 congratulating **R. Varian Sloan** for "his devotion to the ideals and purposes for which the Honolulu Committee on Aging was created." On May 12, Varian was made a Life Member in the Pan American Medical Association in recognition of his "stature and contributions to medicine."

Maurice Silver and **Jerome Tucker** were re-elected trustees of Temple Emanu-El and **John Milnor** was elected treasurer of the Hawaii Association to Help Retarded Children.

On Kauai's political front, **Burt Wade** of Waimea was reappointed to the Board of Health and **Kenneth Fujii** of Kapaa to the Board of Medical Examiners, by Gov. Jack Burns. The State Senate confirmed the reappointment of **Clarence Chang** and **Patrick Cockett** to the University of Hawaii regents only after showing much displeasure over the Regents' decision to reinstate Oliver Lee, the controversial faculty member who won his year-long battle for tenure. We thought Senator Hill's description of Lee interesting: "He is at the top of the pack of strange people from strange places. . . . They are people with warped ideas—long haired, spindle-legged nincompoops who are not here to learn, but to destroy from within."

We were happy to see **Dick Mamiya** selected "Father of the Year in Medicine." Dick, 44, has eight children ranging from 1 to 14. We can well appreciate the truth in his statement, "For a physician's family, any kudos ought to go to the wife and children." He advises young fathers "to take extra effort to consider the early part of their child's life and establish relationships then. Most children are very receptive and observant and adapt to learning. The child can sense more than we realize. The ultimate text of a good father is the product he puts out. All I can hope is that my children can do whatever they undertake and are happy and are responsible and make some contribution."

Visiting Physicians

Stephen Ayres, chief of the respiratory service at St. Vincent's Hospital in New York, was the featured speaker at a Symposium on Respiratory Failure at Kuakini in May. The cherubic but dynamic speaker emphasized how blood gas levels could be related to various arrhythmias. He joked, "The aphorism at our hospital is, 'If patients have to die, they should die with normal blood gases.'"

Robert Petersdorf, a towering, swarthy, ceiling-gazing lecturer from the University of Washington, was visiting professor of medicine at Queen's for two weeks in May. Bob's dogmatic lectures, chock full of interesting information, kept Kam auditorium filled to capacity for two weeks. When treating gram negative shock, which has a 50% to 90% mortality, he said, "the treatment is antibiotics, surgical drainage, fluids, corticosteroids, and most important, psychotherapy for the attending physician. . . ." Bob exhorted us to get at the heart of the FUO problem (fevers of undetermined origin) by applying Willie Sutton's Law. Willie, the famous bank robber, was once asked why he kept robbing banks. Willie's answer was simply, "Because that's where the money is. . . ." We

should be wary of factitious FUO's. Some patients have been known to manipulate their oral and anal sphincters, some use hot water bags or rub the thermometers on the sheets, but the most ingenious bring their own thermometers, which they substitute when the nurse's head is turned.

AMA president **Dwight Wilbur** spoke at a Pacific Club luncheon, where he emphasized that the answer to the problem of quality medical care in a period of rising costs lies in educating the public about the need for adequate health insurance. He predicts that the cost of medical care, particularly in hospitals, will continue to rise. But the solution to providing such care for all Americans does not lie in turning to government, because "government does not do things economically, and it does not lead to quality..." Dwight is also concerned about the 20 to 40 million people in slums and in rural areas who are not getting the benefits of modern medicine. He predicts that the three areas of medicine in which there will be the greatest development in the next 50 years are mental health, degenerative diseases, and control of reproduction. He said, "the freedom that control of reproduction will give to women will, I believe, produce the greatest revolution in the history of mankind..." The medical profession generally must increasingly keep the public and the government informed of what is happening in medicine, of the developments in it... The better educated a person is about his health, the better job he will do and the better job the public will do. As people know, they will be our strongest supporters..."

The 113th Annual Meeting of the Hawaii Medical Association

We failed to make the meeting, so we asked Lee McCaslin to make notes and Lee in turn asked **Bill Bergin**. The following is a hilarious running commentary of Bill's impressions of the HMA meeting in Hilo:

"President **Bob Miyamoto** kicked off one of the most excellently arranged annual meetings ever held. The Arrangements Committee of **Rudy Wiperman**, **Francis Wong**, **Reginald Carvalho**, and **Jim Matayoshi** are to be congratulated. The only difficulty was that no one could find the place. Once found, however, the National Guard Armory proved to be spacious, with generous room for displays and ambulation by the visiting firemen. The first scientific session of the evening of the 27th got off with a bang when **Cliff Moran** fell on his Royal Irish. This gave **Archer Gordon** an excellent opportunity to demonstrate cardiopulmonary resuscitation on the floor of the hall. Jane Talbott, the cardiologist from Intensive, defiantly smoked cigarette after cigarette as she pushed the plugs on her tape recorder. **Jim Mitch-**

ell seemed quite taken with Resusci-Ann's endowments and kept muttering 'Gee Willikers.' I am sure he was preoccupied with the surgical approach, for no one saying 'Gee Willikers' could ever have a prurient thought.

"I finally found out who this *eleu* guy **Blaisdell** is. He is Bill Blaisdell's kid, and is *ohana* to Irene Clark and Carl Bredhoff. No Hawaiian *hoopuniipuni* with this guy!

"Conspicuous by his absence was **Buzz Willett** of Lanai. He now has an assistant, but, is apparently saving his time for the Pocho Paniolo Rodeo coming up next week in Honokaa. Several of the overweight members toddled about in turtle neck, lending a preputial air to the meeting. **Pete Okumoto**, all dignity, was busy checking the displays. **Senior Citizen Kasamoto's** cigar went out when the representative wrapped him up in one of Richard Mfg. Co.'s back braces. The **Al Burdens** cruised with dignity and aplomb through the displays. Ubiquitous '**Curly**' **Batchelder** was at all the scientific sessions accompanied by King of the Health Dept., **Marcus Quisenberry**. **Walter Loo**, the perpetual Mandarin, cruised with proper dignity, shaking his tambourine. **Francis Wong**, athletic director of the Hawaii County Medical Society, Indian wrestled all the detail men. **George Braeher** and Kunimitsu were busy giving away 'Cancer of the Season.' Outstanding papers were *Hypermineralocorticoidism* by **Edward Biglieri**—a rare bird, but interesting. **David Rytand** presented interesting aspects of cardiology, but confused the hell out of Jane Talbott, our cardiologist, when he described the sawtooth tracings of atrial flutter. She has never seen anything but a Demagari saw and wouldn't know a Disston saw even if she fell over one. Hawaii's ichiban pediatrician and sweetheart of Hawaii County Medical Society, **Ruth Oda**, was there in all her pristine glory. Madame Pele was so exuberant she burst into flames and Bill Stearns, the fly boy from Hilo Boy's Club, took the **David Rytands**, **Robert Petersdorf**, and **Herbert Uemura** for a flight over the eruption, accompanied by our hard working executive secretary, Lee McCaslin. Incidentally, Lee is to be congratulated on the hard work she put in to make this such a successful meeting. Enough of this journalistic '*droit de Seigneur*'!"

Queen's Conference

We missed the reading of the winning house staff paper by **Simon Cheng** and his wife Lina Yu entitled *Candida Endocarditis Following Heart Surgery—A Case Report*. Simon dutifully accepted the cash award presented by medical education director James Orbinson. We caught the paper by **Henry Glennie** on the "Wahine" Disaster in Wellington Harbor in 1968, where hypothermia was one of the main causes of death. **Cas Jasinski** asked, "I wonder what the limit of hypothermia is?" **Unoji Goto**,

continued page 554

SHOSEI YAMANOHA, M.D.

1882-1969

Shosei Yamanoha was born on March 3, 1882, in Nago, Okinawa. He received his medical degree from Tokyo Igakko in 1911 and came to Hawaii in December, 1913. Upon receiving his license to practice medicine in 1914 he opened an office in Paia, Maui. In 1914 he moved to Hilo and maintained his practice at Yamanoha Hospital until 1920, when he returned to Japan for further study.

Dr. Yamanoha settled in Hilo permanently in 1923, resuming his practice and becoming an active and respected member of the Japanese community. His devotion to his practice and his generous counsel are still fondly recalled by his friends and former patients.

He was a member of the Hawaii County Medical Society, Hilo Hongwanji, and many civic organizations.

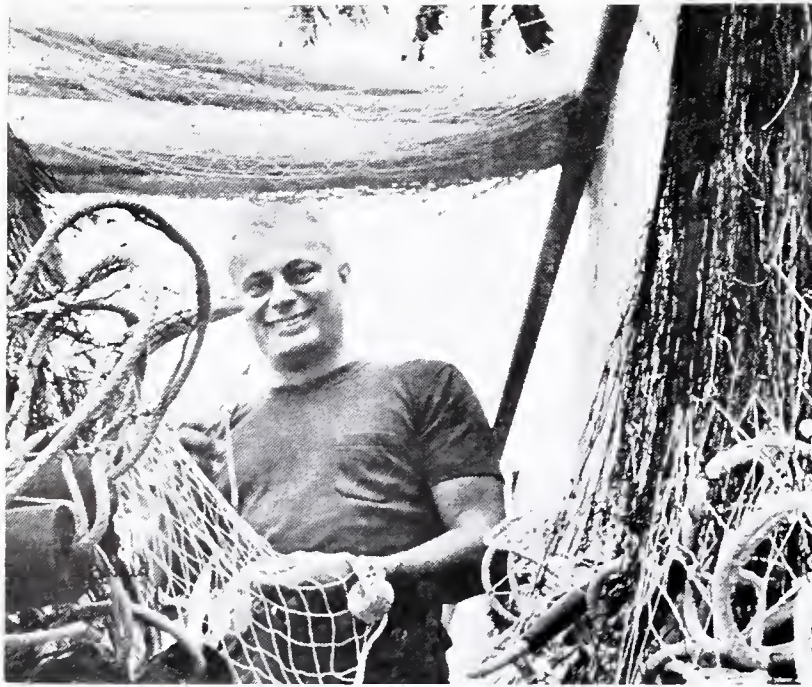
Dr. and Mrs. Yamanoha had five children: Toshimasa and Richard Akira, deceased; Genzo, of Tokyo, Japan; Yone (Mrs. Howard Droste), faculty member of the University of Hawaii Hilo campus; and June, wife of Hilo attorney Cyril Kanemitsu. There are eleven grandchildren.

Mrs. Sei Yamanoha died in 1949.

The late Dr. Richard Yamanoha practiced medicine in Hilo from 1948-1957.

Upon retirement, Dr. Yamanoha moved to Tokyo, where he made his home until his death on April 9, 1969. Up to the time of his death, he was an avid reader of Chinese and classical Japanese literature and a student of Japanese calligraphy. He also devoted many hours to cultivating the flower gardens at his Tokyo residence.

ZENKO MATAYOSHI, M.D.



Our New President

When the hills of Punaluu echo the early morning cry of "SADDLE UP!", it does not portend any great stampede of cattle. Rather, the captain of a worthy crew is calling his fellow fishermen to go out and retrieve the nets, set out the preceding night.

Once a week in the life of George Mills, medicine is partially (though never totally) forgotten, puka pants are donned, and the cool clear waters of the reef soothe the fatigued mind and body of the man recently elected President of the HMA. His three sons usually constitute the crew of his boat—they are his most prized fellow fishermen, while his wife and daughter take over the widows' walk.

All hands turn to when the nets come ashore and the piscatorial prizes are extracted. Wallowing in self-pity, the crew now sets about cleaning the fish, while the captain turns his attention to Hawaiian gourmet cheffing. Pulehu, lawalu, and steamed fish appear as if by magic—in abundance, too—for George Mills and the ocean seem to be of one mind—whatever is needed always seems to be provided.

So, as we say, "Physician, heal thyself!" in this case we may also say, "Fisherman, mend thy nets!" in preparation for the next foray into the blue waters of the Pacific.

On sea or land, George Hiilani Mills has been a busy man. Born in Pepeekeo, on Hawaii, in 1921, and a graduate of Kamehameha Schools, Colorado College, and Boston University School of Medicine, where he earned his M.D. in 1950, George took his internship and medical residency at Queen's Hospital before joining the Alsup Clinic in 1954.

While in college, he met and married Barbara Whitney Frecman of Boston, and they have had four children, George, Kilburn, James, and Elsa.

George is a past president of the Honolulu County Medical Society, the Hawaii Society of Internal Medicine, the Hawaii Heart Association, and the Association of Hawaiian Civic Clubs. He is Medical Director of Kamehameha Schools and Maunalani Convalescent Hospital. He is a member of the board of directors of the American Heart Association, the Hawaii division of the American Cancer Society (and 1968 Cancer Crusade Chairman). He is a past board member of the Liliuokalani Trust Advisory Council and the Council of Social Agencies. He is vice chairman of the Governor's committee on Comprehensive Health Planning, and a member of the Governor's Committee on Act 4 and the Governor's Committee on Vocational Rehabilitation. He is on the executive committee of the Health and Hospital Planning Council and the Regional Medical Program. And he is Hawaii's delegate to the American Medical Association.

The Oahu Health Council gave George its distinguished service award, and the Honolulu Chamber of Commerce named him Medical Father of the Year, in 1965. In 1966 he was given the David Malo award by the West Honolulu Rotary Club and also the Robins Award for community service by a physician. The Association of Hawaiian Civic Clubs recognized him as their outstanding Civic Club member in 1967 and the Outstanding Hawaiian in 1968.

On the record, it seems clear we have an able President—and no one who knows him thinks otherwise! ■

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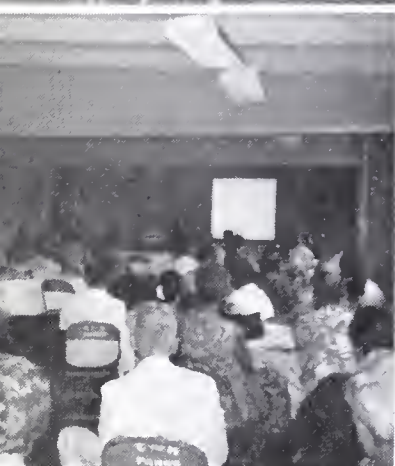
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113th Annual Meeting Hawaii Medical Association

HILO, HAWAII
May 21 through 24

The annual meeting for the one hundred and thirteenth year of corporate existence of the Hawaii Medical Association was held in Hilo in 1969. The following program was presented:

SCIENTIFIC PROGRAM

PAPERS

- Current Concepts of Cardiopulmonary Resuscitation
Archer S. Gordon, M.D.
- Air Quality—Whose Responsibility?
Vaun A. Newill, M.D.
- Recognition of Primary Aldosteronism
Edward G. Biglieri, M.D.
- Current Concepts of Cardiopulmonary Resuscitation
Archer S. Gordon, M.D.
- Air Pollution Health Effects I. Particulate & Sulphur Oxides
Vaun A. Newill, M.D.
- A New Form of Adrenal Hypertension
Edward G. Biglieri, M.D.
- The Failure of Anticoagulants in Coronary Heart Disease
David A. Rytand, M.D.
- Office Methods in Reducing the Risk of Heart Attack
Campbell Moses, M.D.
- Hypermineralocorticoidism
Edward G. Biglieri, M.D.
- Presidential Address
Robert M. Miyamoto, M.D.
- Air Pollution Health Effects II. Other Pollutants
Vaun A. Newill, M.D.
- The Place of Digitalis in Heart Failure with Sinus Rhythm
David A. Rytand, M.D.

- The Identification of Heart Attack Susceptibles
Campbell Moses, M.D.
- Preventive Medicine: The Doctor's Dilemma
Campbell Moses, M.D.
- Hypoxemia and Inappropriate Ventilation in the General Medical and Surgical Patient
Stephen M. Ayres, M.D.
- Diagnosis of Infectious Diseases
Robert G. Petersdorf, M.D.
- $1 + 1 = 1 +$
Max H. Parrott, M.D.
- Management of Respiratory Acidosis
Stephen M. Ayres, M.D.
- Therapy of Infectious Diseases
Robert G. Petersdorf, M.D.
- Mechanism, Recognition, and Management of Atrial Flutter
David A. Rytand, M.D.

SOCIAL PROGRAM

Banquet, Hilo Yacht Club

MEETINGS

- House of Delegates, National Guard Armory
- Scientific Sessions, National Guard Armory
- Woman's Auxiliary, Orchid Isle Hotel

PARTICIPATING DELEGATES

Hawaii County: Reginald S. Carvalho Walter S. L. Loo R. P. Wipperman	John C. Carson Ann B. Catts Charles T. H. Ching Albert C. K. Chun-Hoon William W. L. Dang George M. Ewing Thomas F. Frissell Lawrence H. Gordon George Goto	Reginald C. S. Ho Richard K. B. Ho Winfred Y. Lee Gordon Liu Alfred O. Morris Frances Nakamura Robert A. Nordyke Michael M. Okihiro Alvin A. C. Paraz	Clarence S. Sakai Niall M. Scully Benjamin C. K. Tom Livingston M. F. Wong
Honolulu County: Douglas B. Bell, II Max G. Botticelli Catalino C. Cachero			Kauai County: Robert J. Emrick
			Maui County: Louis S. Rockett J. M. B. Sowers

REFERENCE COMMITTEES

Public Health Douglas B. Bell, II <i>Chairman</i> John Carson Gordon Liu Clarence Sakai R. P. Wipperman	Insurance and Medical Services William W. L. Dang <i>Chairman</i> Albert Chun-Hoon Lawrence Gordon Michael Okihiro J. M. B. Sowers	Miscellaneous Business Charles T. H. Ching <i>Chairman</i> Ann B. Catts Richard K. B. Ho Walter S. L. Loo Niall B. Scully	Parliamentary Affairs Thomas P. Frissell <i>Chairman</i> Robert Emrick George Goto Frances Nakamura Robert Nordyke
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COMMISSIONERS

George Goto.....	COMMISSION ON LEGISLATION
Benjamin C. K. Tom.....	COMMISSION ON PUBLIC AND INTERPROFESSIONAL RELATIONS
Richard D. Moore.....	COMMISSION ON MEDICAL SERVICES
Winfred Y. Lee.....	COMMISSION ON EDUCATION AND SCIENTIFIC RESEARCH
John R. Stephenson.....	COMMISSION ON PUBLIC HEALTH
Coolidge S. Wakai.....	COMMISSION FOR INTERNAL AFFAIRS

Committees 1968-69

AMA-ERF Committee

Douglas B. Bell, II, Chairman (1970)
Bal Raj Mehta (1969)
Buenaventura E. Realica,
Vice Chairman (1970)
Sorrell H. Waxman (1971)
Winfred Y. Lee, Commissioner
George Bracher (Hawaii) (1969)
M. A. Brennecke (Kauai) (1970)
Billie Fern Strother (Maui) (1971)

Adjudication Committee

William W. L. Dang, Chairman (1970)
Kenneth Chinn (1971)
Albert C. K. Chun-Hoon (1969)
Bernard W. D. Fong (1970)
Roy I. Iritani (1971)
B. Allen Richardson,
Vice Chairman (1969)
Clarence S. Sakai (1970)
Richard D. Moore, Commissioner
R. P. Wipperman (Hawaii) (1971)
Samuel R. Wallis (Kauai) (1969)
K. B. McCullom (Maui) (1970)

Arrangements Committee

R. Varian Sloan, Chairman (1970)
R. P. Wipperman, Local Chairman (1970)
Homer R. Benson (1971) (Golf)
George Bracher (1969) (Housing)
Chisato Hayashi (1969) (Fishing)
James K. Matayoshi (1969)
(Golf & Tennis)
James E. Mitchell (1969) (Banquet)
Andrew L. Morgan (1969) (Fishing)
Theo. T. Oto (1969) (Exhibits)
Francis F. C. Wong (1969)
(Sportsmen's Night)
Henry N. Yokoyama (1970) (Tennis)
Livingston M. F. Wong, Ex officio
Coolidge S. Wakai, Commissioner
Eugene Rames (Kauai) (1970)
K. B. McCullom (Maui) (1971)

Association of Professions Committee

Leabert R. Fernandez, Chairman (1970)
Ellis Devereux (1971)
Calvin C. M. Kam (1969)
Audrey W. Mertz, Vice Chairman (1970)
Stephen H. Tenby (1971)
Benjamin C. K. Tom, Commissioner
Harold Lewis (Hawaii) (1969)
Joan J. Takeuchi (Kauai) (1970)
Billie F. Strother (Maui) (1971)

Automotive Safety Committee

Truett V. Bennett, Chairman (1970)
Ralph B. Berry (1969)
William J. Holmes, Vice Chairman (1970)
Carl E. Johnsen, Jr. (1971)
Edmund C. K. Lum (1969)
Donald K. Maruyama (1970)
Michael M. Okihiro (1971)
Roscoe S. Pebley (1969)
Maurice L. Silver (1970)
Robert L. Smith (1971)
John R. Stephenson, Commissioner
Reginald S. Carvalho (Hawaii) (1969)
Burt O. Wade (Kauai) (1970)
James F. Fleming (Maui) (1971)

Awards and Special Projects Committee

Robert A. Nordyke, Chairman (1970)
Max G. Botticelli (1971)
William J. Holmes (1969)
Robert T. S. Jim, Vice Chairman (1970)
Harold M. Johnson (1971)
Bunzo Nakagawa (1969)
Robert A. Rose (1970)
Warren L. H. Wong (1971)
William N. Bergin (Hawaii) (1969)
A. C. Johnston (Kauai) (1970)
John F. Morris (Maui) (1971)
Coolidge S. Wakai, Commissioner

Bureau of Planning and Research Committee

Joseph Oren, Chairman (1970)
Richard K. Blaisdell (1969)
Fred I. Gilbert, Jr. (1970)
Victor Hay-Roe (1971)
Robert L. Kistner (1969)
Stanley E. Kobashigawa (1970)
Wilbur S. Lummis (1971)
Richard T. Mamiya (1970)
Victor M. Mori, Vice Chairman (1969)
J. I. F. Reppun (1970)
R. P. Wipperman (Hawaii) (1971)
Yonemichi Miyashiro (Kauai) (1969)
J. M. B. Sowers (Maui) (1970)

Bylaws and Parliamentary Committee

Harry L. Arnold, Jr., Chairman (1970)
Francis T. C. Au (1970)
Cesar B. DeJesus (1971)
Elmer C. Johnson (1969)
Carl H. Lum, Vice Chairman (1970)
Wilbur S. Lummis (1971)
Roscoe S. Pebley (1969)
Alexander Roth (1970)
Coolidge S. Wakai, Commissioner
H. E. Crawford (Hawaii) (1971)
Albert C. Johnston (Kauai) (1969)
Sakae Uehara (Maui) (1970)

Cancer Committee

Thomas K. L. Lau, Chairman (1970)
Manuel A. Abundo, Jr. (1969)
Samuel D. Allison (1970)
Stanley Batkin (1971)
Ralph B. Berry (1969)
Richard K. Blaisdell (1970)
Thomas C. Brown (1971)
Robert L. Creveling (1969)
William W. L. Dang (1970)
Hans W. Graumann (1971)
Reginald C. S. Ho (1969)
Edward L. S. Jim (1970)
Glenn M. Kokame (1971)
Edmund L. Lee (1969)
Philip J. W. Lee (1970)
Wayne S. Limber (1971)
Wallace W. S. Loui (1969)
Noboru Oishi (1970)
Robert H. Oishi (1971)
Young K. Paik (1969)
Norman R. Sloan (1970)
Grover H. Batten,
Cancer Commission Rep.
Will Drake, Cancer Commission Rep.
John R. Stephenson, Commissioner
George Bracher (Hawaii) (1971)
Robert Emrick (Kauai) (1969)
Robert B. Bjornson (Maui) (1970)

Careers Committee

H. Wm. Goebert, Jr. Chairman (1970)
John Ronald Brown (1969)
Ellis F. Devereux (1970)
Masaru Koike, Vice Chairman (1971)
Ivar J. Larsen (1969)
Donald C. Marshall (1970)
Robert W. Noyes (1971)
Iwao Wm. Shiraki (1969)
Bernice R. Walters (1970)
Benjamin C. K. Tom, Commissioner
James A. Mitchel (Hawaii) (1971)
Gonzalo Geroso (Kauai) (1969)
Robert G. B. Bjornson (Maui) (1970)

Chronic Illness and Aging Committee

L. Clagett Beck, Chairman (1970)
John W. Devereux (1971)
Wilfred T. Ohta (1969)
F. E. Pope (1970)
Kleona Rigney (1971)
R. Frederick Shepard (1969)
Norman R. Sloan, Vice Chairman (1969)
John R. Stephenson, Commissioner
Pete T. Okumoto (Hawaii) (1970)
Eugene D. Rames (Kauai) (1971)
Kenneth Haling (Maui) (1969)

Communicable Disease and Immunization Committee

L. T. Chun, Chairman (1970)
L. Clagett Beck (1970)
Claude V. Caver, Vice Chairman (1969)
Donald F. B. Char (1970)
Richard W. M. Dang (1971)
Ira D. Hirschy (1969)
George Kenessey (1970)
Robert H. Marks (1971)
Roscoe S. Pebley (1969)
Hau N. Vu (1970)
Raymond J. C. Wong (1971)
Henry H. L. Yim (1969)
John R. Stephenson, Commissioner
Verne L. Adams (Hawaii) (1969)
Katok A. Chuang (Kauai) (1970)
John Francis Morris (Maui) (1971)

Crippled Children Committee

Frances Nakamura, Chairman (1970)
Scott C. Brainard (1969)
Louise S. Childs (1971)
Charles T. H. Ching (1970)
Duke Cho Choy, Vice Chairman (1971)
George M. Ewing (1970)
William H. Gullede (1969)
Richard B. Joseph (1971)
Roy M. Kaye (1971)
George Kenessey (1971)
Ivar J. Larsen (1970)
Wallace W. S. Loui (1969)
Carl B. Mason (1969)
James L. Mertz (1970)
Victor M. Mori (1969)
L. Q. Pang (1971)
Richard Pang (1969)
Alan Pavel (1971)
Jordan S. Popper (1971)
Walton K. T. Shim (1971)
John S. Smith (1970)
Coolidge S. Wakai (1971)
John R. Watson (1971)
Raymond J. C. Wong (1971)
John R. Stephenson, Commissioner
Paul J. Caldwell (Hawaii) (1969)
Katok A. Chuang (Kauai) (1971)
Marion Hanlon (Maui) (1969)

Diabetes Committee

Willard Y. Miyahira, Chairman (1970)
Anna Marie Brault, Vice Chairman (1969)
David T. Eith (1970)
Francis Ikezaki (1971)
Ronald D. Moore (1969)
Kleona Rigney (1970)
Louis G. Stuhler (1971)
Sorrell H. Waxman (1969)
John R. Stephenson, Commissioner
Walter S. L. Loo (Hawaii) (1970)
Peter Kim (Kauai) (1971)
A. Y. Wong (Maui) (1969)

Disaster Committee

Casimer Jasinski, Chairman (1970)
Edward W. Boone (1970)
Ellis F. Devereux (1971)
Russell E. Graf (1969)
Calvin C. M. Kam (1970)
Edmund C. K. Lum (1971)
Wilbur S. Lummis (1969)
Mor J. McCarthy (1970)
Rodman B. Miller (1971)
R. S. Pebley (1969)
Millard S. L. Seto, Vice Chairman (1970)
Maurice L. Silver (1971)
Louis G. Stuhler (1971)
Benjamin C. K. Tom, Commissioner
James K. Matayoshi (Hawaii) (1970)
Burt O. Wade (Kauai) (1971)
Sakae Uehara (Maui) (1969)

Fee Survey Committee

Frederick B. Warshauer, Chairman (1970)
Edward W. Boone (1971)
William G. Davis (1969)
Kiyoshi Inouye (1970)
Elmer Johnson, Vice Chairman (1971)
Roy M. Kaye (1969)

Rowlin L. Lichter (1970)
Maurice W. Nicholson (1971)
Noboru Oishi (1969)
L. Q. Pang (1970)
O. D. Pinkerton (1971)
Francis H. Soon (1969)
Paul Y. Tamura (1970)
Jerome L. Tucker (1971)
John R. Watson (1969)
Richard D. Moore, Commissioner
Verne L. Adams (Hawaii) (1969)
Samuel R. Wallis (Kauai) (1970)
W. E. Iaconetti (Maui) (1971)

Filipino Speakers Bureau

Corazon A. Manayan, Chairman (1970)
Gloria N. Badua (1971)
Marciano F. Aquino (1969)
Mario P. Bautista (1970)
Henry A. Manayan (1971)
Buenaventura E. Realica (1969)
Arturo F. Salcedo, Vice Chairman (1970)
Ernesto M. Santos (1971)
Benjamin C. K. Tom, Commissioner
Gonzalo Geroso (Kauai) (1970)
Jose Romero (Maui) (1971)

Finance Committee

Herbert Y. H. Chinn, Chairman
Claude V. Caver (1970)
Kiyoshi Inouye (1971)
Elmer C. Johnson, Vice Chairman (1969)
James L. Mertz (1970)
James K. Matayoshi
(Hawaii County Treasurer)
Thomas P. Frissell
(Honolulu County Treasurer)
Gonzalo Geroso (Kauai County Treasurcr)
Louis S. Rockett
(Maui County Treasurer)

Heart Committee

Coolidge S. Wakai, Chairman (1970)
Anna Maria Brault (1970)
Edward L. Chesne (1971)
Bernard W. D. Fong (1969)
Unoji Goto (1970)
John F. Hanley, Vice Chairman (1971)
George W. Henry (1969)
Richard T. Mamiya (1970)
Rodman B. Miller (1971)
Frances Nakamura (1969)
Kleona Rigney (1970)
Robert Weiner (1971)
John R. Stephenson, Commissioner
Reginald S. Carvalho (Hawaii) (1969)
Katok A. Chuang (Kauai) (1970)
Bertram A. Weeks (Maui) (1971)

Hospital Committee

B. Allen Richardson, Chairman (1970)
Ralph B. Berry (1970)
William W. L. Dang (1971)
Robert K. Mookini, Jr.
Vice Chairman (1969)
Verne C. Waite (1970)
Winfred Y. Lee, Commissioner
H. E. Crawford (Hawaii) (1971)
A. C. Johnston (Kauai) (1969)
Joseph E. Andrews (Maui) (1970)

Indigent Medical Care Committee

Clifford T. Druecker, Chairman (1970)
Raymond M. deHay (1969)
Richard T. Mamiya (1970)
Shigeo Natori (1971)
John M. Ohtani (1969)
Kleona Rigney (1970)
Calvin C. J. Sia (1971)
Patrick J. Walsh, Vice Chairman (1969)
Raymond J. C. Wong (1970)
Richard D. Moore, Commissioner
Verne L. Adams (Hawaii) (1971)
P. M. Cockett (Kauai) (1969)
Kenneth A. Haling (Maui) (1970)

Japanese Speakers Bureau

Takakazu Fukumura, Chairman (1970)
Noboru Akagi (1969)
Keiichi Goshi (1970)
Harry H. Nakata (1971)
Shigeo Natori (1969)

Perry Sumida (1970)
Naomitsu Tajima (1971)
Kazushi Tanaka (1969)
Henry N. Yokoyama, Vice Chairman
(1970)
Benjamin C. K. Tom, Commissioner
Theo. T. Oto (Hawaii) (1971)
Kenneth K. Fujii (Kauai) (1969)
K. Izumi (Maui) (1970)

Legislative Committee

George Goto, Chairman (1970) &
Commissioner
Donald F. B. Char (1969)
Clarence F. Chang (1969)
Philip T. Chu (1970)
Richard W. D. Dang (1971)
Cesar B. DeJesus (1969)
John W. Devereux (1970)
H. Wm. Goebert, Jr. (1971)
Roy Kuboyama (1969)
Richard K. C. Lee (1970)
P. Howard Liljestrand (1971)
K. Y. Lum (1969)
Bal Raj Mehta (1970)
Andrey W. Mertz (1971)
James L. Mertz (1969)
Richard S. Omura, Vice Chairman (1970)
F. J. Pinkerton (1971)
Walter B. Quisenberry (1969)
Arturo F. Salcedo (1970)
George F. Schnack (1971)
Calvin C. J. Sia (1969)
Francis M. Terada (1970)
John R. Watson (1971)
Pete T. Okumoto (Hawaii) (1969)
Kenneth K. Fujii (Kauai) (1970)
Clifford F. Moran (Maui) (1971)

Maternal & Perinatal Mortality Study Committee

Francis M. Terada, Chairman (1970)
Mario P. Bautista (1970)
Ann B. Catts (1970)
George Goto (1971)
William H. Hindle (1969)
Francis M. Ikezaki (1971)
Robert T. S. Jim (1970)
Roy M. Kaye (1970)
G. Koch-Brar (1970)
John A. Krieger (1971)
Frederick S. F. Lee (1970)
Corazon A. Manayan (1971)
Paul F. McCallin (1971)
Arno J. Mundt (1970)
Bunzo Nakagawa (1970)
Herbert M. Nakata (1969)
Shigeo Natori (1970)
Harold Y. Nekonishi (1970)
Noboru Ogami, Vice Chairman (1970)
John M. Ohtani (1969)
Gordon C. Ontai (1970)
Arthur T. Osako (1971)
Stanley M. Saiki (1970)
Richard Y. Sakimoto (1971)
Millard S. L. Seto (1969)
Walton K. T. Shim (1971)
David A. Sinclair (1969)
Betty S. M. Soo (1969)
Francis H. Soon (1970)
John R. Stephenson, Commissioner
Mitsuo Tottori (1970)
Theodore K. L. Tseu (1970)
Herbert S. Uemura (1970)
Hau N. Vu (1971)
Sorrell H. Waxman (1971)
James T. S. Wong (1970)
Paul J. Caldwell (Hawaii) (1971)
Clyde H. Ishii (Kauai) (1971)
H. Lawrence Allred (Maui) (1971)

Medical Care Plans & Fees Committee

John J. Lowrey, Chairman (1970)
William W. L. Dang (1970)
Gail G. L. Li (1971)
John J. Lowrey, Vice Chairman (1969)
Carl H. Lum (1970)
Robert K. Mookini, Jr. (1971)
William F. Moore, Jr. (1969)
Noboru Oishi (1970)
Robert W. Peyton (1971)
Francis H. Soon (1969)
Richard D. Moore, Commissioner
William N. Bergin (Hawaii) (1970)
Samuel R. Wallis (Kauai) (1971)
William E. Iaconetti (Maui) (1969)

Medical Education Committee

Max G. Botticelli, Chairman (1970)
Raymond H. Fujikami (1970)
Norman Goldstein (1971)
Lawrence H. Gordon (1969)
George Goto (1970)
Richard Mamiya (1971)
Robert A. Nordyke, Vice Chairman
(1969)
Robert W. Noyes (1969)
Daniel D. Palmer (1970)
Millard S. L. Seto (1971)
Sorrell H. Waxman (1969)
Winfred Y. Lee, Commissioner
George Bracher (Hawaii) (1970)
M. A. Brennecke (Kauai) (1971)
Robert B. Bjornson (Maui) (1969)

Medical Practice Act Committee

B. Allen Richardson, Chairman (1970)
Walter B. Quisenberry (1970)
George Goto, Commissioner
Theo. T. Oto (Hawaii) (1971)
Burt O. Wade (Kauai) (1969)
Sakae Uehara (Maui) (1970)

Medicine and Religion Committee

Francis H. Soon, Chairman (1970)
Howard Honda (1970)
Maurice Howell (1971)
Frederick S. F. Lee (1969)
Mor J. McCarthy (1970)
Wilfred T. Ohta (1971)
Walter S. Strode, Vice Chairman (1969)
Benjamin C. K. Tom, Commissioner
James A. Mitchel (Hawaii) (1970)
Eugene Rames (Kauai) (1971)
J. M. B. Sowers (Maui) (1969)

Mental Health Committee

K. Y. Lum, Chairman (1970)
Cora L. Au (1969)
Duke Cho Choy (1970)
Edward F. Furukawa (1971)
Maurice Howell (1969)
Audrey W. Mertz (1970)
Miguel R. Rivera (1971)
William H. Sage (1969)
Leigh Sakamaki (1970)
George F. Schnack, Vice Chairman (1971)
Robert Weiner (1969)
William W. T. Won (1970)
John R. Stephenson, Commissioner
Charles H. Belcher (Hawaii) (1971)
Joan J. Takeuchi (Kauai) (1969)
Charles W. Stewart, Jr. (Maui) (1970)

Message of the Month Committee

William F. Moore, Jr., Chairman (1970)
John Gene Ahern (1971)
Gail G. L. Li (1969)
John Roberts (1970)
Kazuo Teruya, Vice Chairman (1971)
Benjamin C. K. Tom, Commissioner
Ruth E. Oda (Hawaii) (1969)
Patrick M. Cockett (Kauai) (1970)
J. M. B. Sowers (Maui) (1971)

National Legislation Committee

Cesar B. DeJesus, Chairman (1971)
Bernard W. D. Fong (1969)
Richard K. C. Lee (1971)
Wilbur S. Lummis, Vice Chairman (1969)
L. Q. Pang (1970)
Don E. Poulson (1971)
E. Lee Simmons (1969)
George Goto, Commissioner
Verne L. Adams (Hawaii) (1970)
Clyde H. Ishii (Kauai) (1971)
Clifford Moran (Maui) (1969)

Negotiating Committee

Chew Mung Lum, Chairman (1970)
Grover H. Batten (1971)
Don E. Poulson, Vice Chairman (1969)
B. Allen Richardson (1970)
Richard D. Moore, Commissioner
William N. Bergin (Hawaii) (1969)
Yonemichi Miyashiro (Kauai) (1970)
J. M. B. Sowers (Maui) (1971)

News Media Committee

Henry N. Yokoyama, Chairman (1970)
John Gene Ahern (1971)
Claude V. Caver (1969)
Ellis F. Devereux, Vice Chairman (1970)
Rowlin L. Lichter (1971)
Bal Raj Mehta (1969)
J. I. F. Reppun (1970)
Alexander Roth (1971)
Stephen H. Tenby (1969)
Benjamin C. K. Tom, Commissioner
Pete T. Okumoto (Hawaii) (1969)
W. W. Goodhue (Kauai) (1970)
Robert G. B. Bjornson (Maui) (1971)

Nominating Committee

Thomas P. Frissell, Chairman (1970)
William W. L. Dang
John J. Lowrey
Theodore T. Tomita
Coolidge S. Wakai
David Wm. Jones (Hawaii)
J. Mark B. Sowers (Maui)
Samuel R. Wallis (Kauai)

Nurses Liaison Committee

H. H. Chun, Chairman (1970)
Manuel A. Abundo, Jr. (1969)
Stanley E. Batkin (1970)
William G. Davis (1971)
William H. Hindle (1969)
Ronald D. Moore (1970)
Robert H. Oishi, Vice Chairman (1971)
Benjamin C. K. Tom, Commissioner
Etta W. Best (Hawaii) (1969)
Robert Emrick (Kauai) (1970)
Joseph E. Andrews (Maui) (1971)

Operation Pacific Committee

Thomas H. Richert, Chairman (1970)
L. Clagett Beck (1971)
Anna Marie Brault (1969)
Claude V. Caver (1970)
Unoji Goto, Vice Chairman (1971)
Richard S. Omura (1969)
Robert W. Peyton (1970)
Benjamin C. K. Tom, Commissioner
Paul J. Caldwell (Hawaii) (1971)
Gonzalo Geroso (Kauai) (1969)
Milton M. Howell (Maui) (1970)

Pharmacy Committee

John F. Chalmers, Chairman (1970)
Ralph B. Berry (1971)
Frederick S. F. Lee (1969)
Willard Y. Miyahira (1970)
Daniel D. Palmer, Vice Chairman (1971)
Harry C. Shirkey (1969)
George Goto, Commissioner
Reginald S. Carvalho (Hawaii) (1969)
Robert J. Emrick (Kauai) (1970)
J. M. B. Sowers (Maui) (1971)

Publications Committee

Frank McDowell, Chairman (1970)
Samuel D. Allison, Vice Chairman (1970)
Harry L. Arnold, Jr., ex officio
Herbert Y. H. Chinn, Treasurer
Robert L. Creveling (1971)
Richard W. Fardal (1969)
Norman Goldstein (1970)
Richard T. Mamiya (1971)
George H. Mills, President-elect
Robert M. Miyamoto, President
R. Varian Sloan, Secretary
Winfred Y. Lee, Commissioner
William N. Bergin (Hawaii) (1969)
Kenneth K. Fujii (Kauai) (1970)
Frank A. St. Sure (Maui) (1971)

Public Relations Committee

H. Wm. Goebert, Jr., Chairman (1970)
Stanley E. Batkin (1970)
Robert C. H. Chung (1971)
William W. L. Dang (1969)
Cesar B. DeJesus (1970)
Fred I. Gilbert, Jr. (1971)
Andrew C. Ivy, Jr. (1969)
P. Howard Liljestrand (1970)

O. D. Pinkerton (1971)
Herbert Uemura (1969)
Henry N. Yokoyama, Vice Chairman (1970)
Benjamin C. K. Tom, Commissioner
William N. Bergin (Hawaii) (1971)
Gonzalo Geroso (Kauai) (1969)
Robert G. B. Bjornson (Maui) (1970)

Quackery Committee

William H. Sage, Chairman (1970)
Frederick A. Dodge (1971)
Michael F. Hase (1969)
Reginald C. S. Ho (1970)
Carl E. Johnsen, Jr. (1971)
William J. Natoli (1969)
Maurice W. Nicholson (1970)
Hideo Oshiro, Vice Chairman (1971)
Alan Pavel (1969)
Francis H. Soon (1971)
Stephen H. Tenby (1969)
Benjamin C. K. Tom, Commissioner
Shizuto Mizuire (Hawaii) (1970)
Yonemichi Miyashiro (Kauai) (1971)
L. S. Rockett (Maui) (1969)

Radiation Committee

George W. Henry, Chairman (1970)
Thomas C. Brown (1969)
Russell E. Graf (1970)
Hans W. Graumann (1971)
Philip J. W. Lee (1969)
William J. Natoli (1970)
Robert A. Nordyke, Vice Chairman (1971)
Robert G. Rigler (1969)
John R. Stephenson, Commissioner
George Bracher (Hawaii) (1970)
A. C. Johnston (Kauai) (1971)
Robert B. Bjornson (Maui) (1969)

School Health Committee

Calvin C. J. Sia, Chairman (1970)
Donald F. B. Char (1969)
Louise S. Childs (1970)
Michael F. Hase (1971)
Roy Kuboyama, Vice Chairman (1969)
Felix J. Lafferty (1970)
Donald C. Marshall (1971)
Audrey W. Mertz (1969)
William F. Moore, Jr. (1970)
F. E. Pope (1971)
Leigh Sakamaki (1969)
Stephen H. Tenby (1970)
Raymond J. C. Wong (1971)
John R. Stephenson, Commissioner
Francis F. C. Wong (Hawaii) (1969)
P. M. Cockett (Kauai) (1970)
James F. Fleming (Maui) (1971)

Scientific Program Committee

Livingston M. F. Wong, Chairman (1970)
Richard K. Blaisdell (1970)
Richard K. B. Ho (1971)
Robert T. S. Jim (1969)
Fred E. Pope (1970)
Buenaventura E. Realica (1971)
Walton K. T. Shim (1969)
R. Varian Sloan (1970)
K. S. Tom (1971)
Herbert S. Uemura, Vice Chairman (1969)
Coolidge S. Wakai, Commissioner
Harold Lewis (Hawaii) (1970)
Eugene Rames (Kauai) (1971)
K. B. McCullom (Maui) (1969)

Television-Radio Committee

Herbert Uemura, Chairman (1970)
Claude V. Caver (1971)
Clifford B. G. Chang (1970)
Raymond H. Fujikami (1969)
Robert T. S. Jim (1971)
Robert Lee, Jr. (1970)
Rowlin L. Lichter (1969)
George H. Nip (1971)
Miguel Rivera (1970)
Milton Trager (1969)
Theodore K. L. Tseu, Vice Chairman (1971)
Philip Watt (1970)
Henry N. Yokoyama, Vice Chairman (1969)

Benjamin C. K. Tom, Commissioner
George Bracher (Hawaii) (1969)
W. W. Goodhue (Kauai) (1970)
Robert G. B. Bjornson (Maui) (1971)

Water Safety Committee

Arno J. Mundt, Chairman (1970)
Roger B. Brault (1971)
Wayne S. Limber (1969)
Michael M. Okihiro, Vice Chairman (1970)
John R. Stephenson, Commissioner
Pete T. Okumoto (Hawaii) (1971)
M. A. Brennecke (Kauai) (1969)
Ken McCullom (Maui) (1970)

Woman's Auxiliary Committee

Donald A. Jones, Chairman (1970)
Gordon Y. H. Chang (1970)
Philip M. Corboy, Vice Chairman (1970)
Edward T. Emura (1969)
Victor Hay-Roe (1970)
Harold G. Lawson (1971)
Benjamin C. K. Tom, Commissioner
Francis F. C. Wong, (Hawaii) (1969)
Joan J. Takeuchi (Kauai) (1970)
Sakae Uehara (Maui) (1971)

Workmen's Compensation Committee

Don E. Poulson, Chairman (1970)
Edward L. Chesne (1970)
Raymond C. Dusendschon (1971)
Lawrence H. Gordon (1969)
Francis M. Ikezaki (1970)
Kiyoshi Inouye (1971)
Calvin C. M. Kam (1969)
Donald K. Maruyama (1970)
Robert K. Mookini, Jr., Vice Chairman (1971)
Alan Pavel (1969)
Richard D. Moore, Commissioner
Verne L. Adams (Hawaii) (1970)
W. W. Goodhue (Kauai) (1971)
J. A. Burden (Maui) (1969)

Ad Hoc Committee to Work on Implementation of HR 53

Donald F. B. Char, Chairman
Louise S. Childs
Michael F. Hase
Roy Kuboyama
Felix J. Lafferty
Leigh Sakamaki
Calvin C. J. Sia, Vice Chairman
Ann Barbara Ho Yee
John R. Stephenson, Commissioner
Ruth E. Oda (Hawaii)
P. M. Cockett (Kauai)
James F. Fleming (Maui)

Ad Hoc Search Committee

William E. Iaconetti, Chairman
Herbert Y. H. Chinn
R. Varian Sloan
Patrick M. Cockett (Kauai)

Ad Hoc Committee to Study RMP

Richard D. Moore, Chairman
Morton E. Berk
Winfred Y. Lee
John J. Lowrey
Chew Mung Lum
George H. Mills
Joseph Oren

Ad Hoc Committee to Develop HMA Position on Drug Abuse

John R. Stephenson, Chairman
Donald F. B. Char
Frederick A. Dodge
B. R. Mehta
Audrey W. Mertz
Calvin C. J. Sia
H. Wm. Goebert, Jr.
Felix J. Lafferty
Walter E. Batchelder (Hawaii)
Albert C. Johnston (Kauai)
Dorothy N. La Fon (Maui)

SPECIAL APPOINTMENTS

Governor's Planning Committee on Prevention and Control of Alcoholism—William H. Sage
 State Highway Safety Council—Truett V. Bennett, Albert C. K. Chun-Hoon
 Hawaii Alliance for the Eradication of Venereal Disease—George Goto
 Examining Board for Hansen's Disease—Wilfred Kurashige
 Interprofessional Coordination—Leahert R. Fernandez, Theodore T. Tomita
 Medical Advisory Committee to the University of Hawaii's Student Health Services—Bernard Fong
 State Employees' Retirement Plan Review Board—Grover H. Batten, Thomas S. Bennett, C. M. Lum,
 Don Poulson, Francis Oda, William Won, Coolidge Wakai, Albert Chun-Hoon
 Inter-Society Science Education Council—Robert A. Nordyke
 University of Hawaii Environment Poison Study Committee—Richard K. B. Ho
 Department of Health Radiation Advisory Committee—Robert A. Nordyke
 Anti-Smoking Program—John R. Stephenson, Implementation of Act 58—George Goto
 H&HPC Medical Center Action Committee—George Goto
 Hawaii Curriculum Center—Richard T. Mamiya
 State Commission on Children and Youth, liaison with Maternal & Perinatal Mortality
 Study Committee—Roy M. Kaye, Drug Abuse—John R. Stephenson
 State Commission on Hospitals—Toru Nishigaya
 Inter-Industry Workmen's Compensation Study Committee—Don Poulson
 Heart Program—Coolidge S. Wakai
 Honolulu Mental Retardation Coordinating Committee—George Goto
 The National Foundation's Health Scholarship Committee—C. M. Burgess
 Legislature's Ad Hoc Committee to Study Use of Drugs by Their Generic Names—John F. Chalmers
 Medical Advisory Board to the Hawaii Hospital Association—B. A. Richardson, Francis T. Oda
 Hawaii State Vocational Plan—Edward W. Colby, George F. Schnack, Coolidge S. Wakai, R. F. Shepard
 Mental Health Association Planning Group—William J. T. Cody
 Department of Health; Emergency Medical Services Workshop Planning—Truett V. Bennett
 Hawaii Emergency Medical Stockpile Study—Casimer J. Jasinski
 Committee to Eradicate German Measles in Hawaii—L. T. Chun
 U. of H. Medical School—Max G. Botticelli, ex officio
 Health and Community Services Council, Health Division—Winfred Y. Lee
 Regional Medical Program Cancer Committee—William W. L. Dang



This attractive office plaque, available from the American Medical Association, will encourage better understanding between you and your patients. Suitable for wall or desk display, the plaque measures 6" x 10½". The lettering is white on a dark brown background and the frame is durable beige plastic. The plaque is designed to

blend well with any office decor. Cost of the plaque is \$1.25, postpaid. To place your order, write to the Order Department, American Medical Association. Make check payable to the AMA.

AMERICAN MEDICAL ASSOCIATION
 535 North Dearborn Street • Chicago, Ill. 60610

PROCEEDINGS OF THE HOUSE OF DELEGATES

113th Annual Meeting of the Hawaii Medical Association

The first session of the House of Delegates of the Hawaii Medical Association was called to order by the president-elect, George H. Mills, at 1:00 P.M., May 21, 1969, in the Hilo National Guard Armory.

Present were (officers) George H. Mills (Chairman pro tem), B. Allen Richardson, R. Varian Sloan, Herbert Y. H. Chinn, and Robert M. Miyamoto; (county presidents) K. S. Tom, Albert C. Johnston, and John F. Morris; (councilors) Grover H. Batten, Bernard W. D. Fong, William E. Iaconetti, David Wm. Jones, John J. Lowrey; (Honolulu Delegates) Douglas B. Bell, II, Ann B. Catts, Charles T. H. Ching, Albert C. K. Chun-Hoon, William W. L. Dang, Thomas P. Frissell, George Goto, Reginald C. S. Ho, Richard K. B. Ho, Winfred Y. Lee, Gordon Liu, Michael M. Okihiro, Clarence S. Sakai, Niall M. Scully, Livingston M. F. Wong; (Kauai Delegate) Robert J. Emrick; (Maui Delegate) Sakae Uehara; (Hawaii Delegates) Reginald S. Carvalho, Walter S. L. Loo, R. P. Wiperman.

Honolulu president, K. S. Tom, asked that the following alternate delegates be seated to complete Honolulu County's delegation: Max G. Botticelli for Scott C. Brainard, Catalino C. Cachero for Frederick A. Dodge, George M. Ewing for Edward L. S. Jim, Lawrence H. Gordon for George H. Nip, Alfred O. Morris for Walter S. Strode, Frances Nakamura for Don E. Poulson, Robert A. Nurdyke for Dudley S. J. Seto, Alvin A. C. Paraz for Calvin C. J. Sia.

Maui president, John F. Morris, asked that alternate delegate J. Mark B. Sowers be seated for Louis S. Rockett.

The minutes of the May 22-25, 1968, meeting were approved as published.

Dr. William W. L. Dang was appointed parliamentarian.

The Honolulu County delegation requested a ten-minute recess to caucus.

Mr. Richard Layton, AMA Field Service Representative, and Mr. William Watson, director of AMPAC, were introduced to members of the House.

A correction in recommendation No. 2 of the ad hoc Search Committee was noted. It should read as follows: "(2) The purposes for which this committee were established have been achieved, but it should not be disbanded until after an evaluation of the concept is made."

Dr. George W. Ewing was asked to serve on the Reference Committee on Public Health to replace John C. Carson.

Dr. Robert M. Miyamoto, president, was welcomed with a standing ovation.

It was voted to reconvene the House of Delegates on Thursday, May 22, at 1:00 P.M.

The Reference Committees were in session May 21, beginning at 2:00 P.M.

The second session of the House of Delegates was called to order on Thursday, May 22, 1969, at 1:00 P.M. Dr. Mills continued to act as Chairman pro tem. The secretary called the roll. Drs. Benjamin C. K. Tom and Yonemichi Miyashiro, who were absent for the first session, were present for the second session. Drs. B. A. Richardson and Robert M. Miyamoto, who were present the first day, did not answer the roll call on the second day.

Dr. Max H. Parrott, member of the Board of Trustees of the American Medical Association, was introduced and asked to say a few words to the members of the House.

PUBLIC HEALTH REFERENCE COMMITTEE

Mr. President and members of the House of Delegates:

Your Reference Committee met before an audience of interested physicians and guests. It received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussion of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AUTOMOTIVE SAFETY

The committee has met four times since May, 1968. A Health Department application for a grant to study aspects of injury control was considered and endorsed. In anticipation of a Medical Advisory Board for Drivers' Licensing being requested by the State authorities, this Board was organized and Dr. William J. Holmes chosen as its chairman. The Board has been inactive pending authorization from legislation.

The question of which diseases or disabilities should be made legally reportable to the Driver's Licensing Bureau was considered but no firm opinion could be reached. This is such a potentially troublesome problem medicolegally that it would be wiser to develop a policy after experience is gained by the functioning of the Medical Advisory Board.

A proposed symposium on emergency care problems by the Health Department was endorsed. This symposium will utilize mainland authorities and will be directed to interested physicians as well as paramedical personnel. No budget requests are anticipated.

RECOMMENDATIONS: (1) That the committee continue functioning as is. (2) In addition, I believe that by cooperation with the Public Relations Committee, some sort of education program of the public in such matters as the danger of alcohol and driving, and so forth, would be beneficial and appropriate.

TRUETT V. BENNETT, M.D.

Automotive Safety

Your Committee first considered the Automotive Safety Committee Report. No one appeared to discuss this report. Your Committee recommends approval of this report and commends the committee for its efforts in this important area.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CHRONIC ILLNESS & AGING

The committee held three meetings this year. The first two meetings concerned themselves with the relationship to the Commission on Aging in regard to cooperation in a program on geriatrics. It was emphasized that the previous proposed Workshop did not receive much response, therefore, it was suggested that in place of this type of program an outstanding speaker be obtained for the HMA Annual Meeting in the field of geriatrics. However, arrangements for furthering this program were not resolved in time to put on this program for the 1969 HMA Annual Meeting.

A request was received regarding a Committee on Hearing Conservation. It was felt that this problem should be referred to the Hawaii EENT Society since the Chronic Illness & Aging Committee is oriented more towards geriatrics. It is hoped that the program on hearing conservation can be supported by the medical profession and not controlled by a nonmedical organization.

The last meeting of the committee, held on May 1, was in regard to correspondence regarding Regional Faculty Training. This was reviewed and it was felt this

matter should be pursued further and correspondence is being carried out with the Pennsylvania Medical Society for further details of this program. The committee felt this program would fit in well with the original thought of putting on a limited program in geriatrics, preferably at the HMA 1970 Annual Meeting, in the form of some outstanding speaker who is well versed in geriatric medical problems.

There is no budget request.

RECOMMENDATIONS: (1) That discussion of matters relative to a workshop be carried on early in 1969-1970 in order that sufficient time will be given to make necessary arrangements. (2) That the Chairman of the Scientific Program Committee for 1969-70 and the Continuing Health Education Council be notified of the objectives of this committee.

L. CLAGETT BECK, M.D.

Chronic Illness and Aging

Your Committee considered the report on Chronic Illness and Aging Committee and recommends approval of its report. Again this area is and will be important in the years to come.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNICABLE DISEASE AND IMMUNIZATION, VENEREAL DISEASE, AND TUBERCULOSIS

Venereal Disease Program: The State Department of Health is in accord with our committee in the establishment of a Venereal Disease Prevention Program through education both by the State and by the Department of Education. The implementation of the educational program will depend on the Department of Health's ability to get the necessary funds.

Communicable Disease: The committee endorses the purpose of the "committee to eradicate german measles in Hawaii" in regards to a statewide educational campaign for both medical and lay people and to set up guide lines for the use of rubella vaccine.

Hansen's Disease: A subcommittee on leprosy evaluated the present Hawaii leprosy program and made suggestions in the areas of diagnosis, case findings, prevention and prophylaxis, admission to treatment institutions, rehabilitation, and public education programs. The committee recommended to the Council that it ask the Legislative Committee to see that the Revised Laws of Hawaii are amended to delete reference to leprosy control and that such control as deemed necessary and desirable be a subject of the Department of Health Regulations; and that HMA feels that the enforced institutionalized isolation of leprosy patients is not now medically indicated.

There are no recommendations or budget requests.

L. T. CHUN, M.D.

Communicable Disease and Immunization, Venereal Diseases, and Tuberculosis

Your Committee then considered the above report and Dr. Quisenberry, Director of the Department of Health, expanded on his Department's efforts in this area. The Committee recommends approval of this report and wishes to especially call attention to the change in the Hansen's Disease laws being acted upon by the present Legislature.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DIABETES

Diabetes screening programs were carried on in Kauai, Maui, Hawaii, and Oahu with the following preliminary results:

	PREVIOUSLY			
	NONDIABETIC	KNOWN	NEW	OTHER
Kauai	37	1	38	..
Maui	28	2	13	..
Hawaii (East)	58	7	57	1
Hawaii (West)	21	4	13	..
Oahu	48	13	17	2

The collected statistics were sent to the American Diabetes Association. The cost of Dextrostix was borne by the Department of Health.

The Diabetes Workshop for Nurses was completed successfully jointly with the State Department of Health. It was conducted on Maui, Hawaii, and Oahu. Several of the Kauai nurses attended the sessions on Oahu.

The Camp for Diabetic Children was also carried out successfully. One child from Maui attended. It was the consensus of children and parents that those present matured physically, emotionally, and intellectually. We hope to carry on a longer and better camp this year.

Hawaii Diet Manual is still being revised and has not been reviewed by this committee.

A Diabetic Workshop for Licensed Practical Nurses (LPN's) was held by the LPN Association, and the State Department of Health which we helped to plan and carry out. This one-day workshop served to further current knowledge in diabetes and newer methods in nursing.

A Diabetes Detection Program for the South Pacific Islands is being worked out and it is hoped that we will be able to coordinate our services with the East-West Center Health Services. Final draft will be sent to the Council for approval.

RECOMMENDATIONS: (1) That the HMA continue to encourage the county societies to take leadership in conducting diabetes detection programs. (2) That next year's committee continue to look into new areas of community service, including the South Pacific Basin. (3) That next year's committee continue to work with the Hawaii Nurses Association, the Diabetes Association, and the YMCA to carry on the Diabetes Camp for Children. (4) That the HMA encourage physicians to send their diabetic children to the summer camp. (5) That next year's committee continue to encourage and assist in the conducting of seminars and workshops on diabetes for the paramedical groups in Hawaii.

WILLARD Y. MIYAHIRA, M.D.

Diabetes

Your Committee then considered the report of the Diabetes Committee, and commends it and its chairman on their work during the year. We do recommend, however, that the second sentence in the fourth paragraph be deleted and not become a part of the proceedings of the House of Delegates. We concur in all the recommendations except for clarity we recommend that the word "their" should be deleted in the fourth recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE TO STUDY DRUG ABUSE

This committee was formed shortly before the annual meeting and has not yet had an opportunity to meet. Still missing is a representative from the Medical Education Committee. The chairman is unable to serve and since physician education is an important facet of the over-all picture, the Medical Education Committee should be represented. Representations from the Public Relations, Legislative, and School Health committees have been appointed to assist in developing the HMA position which should include reference to State and Federal statutes, health education, physician education, and delivery of service. In addition to drug abuse, the committee will also propose a more detailed policy on smoking.

The committee would appreciate suggestions from the House of Delegates.

There is no budget request.

RECOMMENDATIONS: (1) That the committee be expanded to include representation from the Medical Education Committee. (2) That the committee start its study as soon as possible after the conclusion of the HMA's Annual Meeting and provide preliminary reports to the Council.

JOHN R. STEPHENSON, M.D.

Ad Hoc Committee to Study Drug Abuse

The Committee then met to consider this ad hoc committee report. It feels that this important committee should be continued and that its recommendations be approved. In addition we feel that the Department of Education and the Department of Health should be consulted and their help in this matter solicited.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HEART

The committee held one meeting, on April 16, 1969, to review methods of developing better communications between the HMA Heart Committee and various organizations that are active in the field of heart disease.

The heart disease control activities of the Department of Health were reviewed. In the first ten months of 1968, 563 cases of possible cardiac abnormalities picked up by the mobile x-ray units were referred to physicians. At the 1968 Health Fair blood pressure screening was done for 1,709 people and 10.5% were found to be abnormal. A phonocardiogram machine was purchased by the Chronic Disease Branch. A pilot program has been established for fourth graders in low-income areas. The follow-up of over-age discharges of the Crippled Children's Service was discussed. A report of the activities of the Interagency Council on Smoking and Health was received. Five Travenol cardiopulmonary resuscitators have been acquired under Act 97 and attendants are being retrained under RMP on cardiac massage, cardiopulmonary resuscitation, and the use of the machines. Subsidies were received to provide for coronary care unit training and workshop programs were developed for nurses and physicians. Subsidies are also providing for research on cardiovascular disease at Queen's and myocardial infarction at Kaiser.

RMP activities were also reviewed. Despite the reduction of project funds for the Coronary Care Training Project to \$53,966, the committee was advised that the modified grant application actually provides for the training of more physicians and nurses than originally planned. The revised program outline was reviewed by the committee.

Dr. Sage reported on the Heart Association activities, which provided CPR training in fiscal 1968-69 for more than 657 physicians and 147 nurses, 60 dentists, 142 paramedical personnel, 388 industrial supervisors, 40 water safety personnel, 59 firemen, and 111 police officers. He advised the first CCU operation at Queen's resulted in an estimated reduction of approximately 53% in the mortality rate from acutely ill heart patients, with the mortality rate down from 28% to 13%. The Heart Association proposes to double the coronary care management program provided to nurses and physicians. The electrocardiogram's analysis of 656 individuals during the Health Fair detected cardiac abnormalities in 17%. HHA hopes to purchase additional cardioanalyzers and make this screening available throughout the State. The following research projects are being given financial support: Kuakini Medical Research Institute, comparing immunoglobulin levels, low density lipoprotein patterns and platelet aggregating activities of normal individuals with those who have suffered a myocardial infarction; University of Hawaii, investigation of the mechanism of cold stored cardiac activity; University of Hawaii, investiga-

tion of hypocholesterolemia in malaria; University of Hawaii, study of the energy-producing system of the heart; University of Hawaii, investigation of the correlation of diet and incidence of coronary artery disease by controlling the diet of laboratory rats and Japanese quail; University of Hawaii, investigation of atherosclerosis in pigeons regarding the role of exercise; Queen's Medical Center, continuing investigation of racial groups having a markedly higher incidence of coronary artery disease; and two junior research fellowships. The Heart Association's largest educational effort was "Hearts and Husbands," which was held in conjunction with its annual meeting.

There is no budget request.

RECOMMENDATION: (1) That the Heart Committee continue its liaison with agencies and organizations which have activities in the area of heart disease and keep the membership informed.

COOLIDGE S. WAKAI, M.D.

Heart

The Committee then considered the report of the Heart Committee and concurred in its recommendations. This area is a very large one and will continue to grow in the years to come, especially with the involvement of RMP programs.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MATERNAL AND PERINATAL MORTALITY STUDY

The committee has reviewed and classified six maternal deaths for the year 1968. Its subcommittee reviewed eight perinatal deaths and two were discussed and classified by the "big committee." A total number of 211 perinatal deaths occurred in the State for 1968.

The questionnaires of the ACOG-sponsored National Study of Maternity Care were sent to the chiefs of the OB-GYN departments of each hospital and these were filled and submitted by each hospital directly to the ACOG office in Chicago, Illinois. This committee's assistance was not actually required in getting the questionnaires returned.

Action has not yet been taken on the matter of the new death certificates' not providing information regarding a recent pregnancy.

From time to time members of the committee have asked whether or not the educational function of this committee was being carried out. Although minutes of our meetings are sent to the attending physicians, they do not receive the benefit of the listening to the entire analysis of each case.

Since Dr. Roy Kaye's resignation in August, 1968, as chairman of the subcommittee which screens all perinatal deaths, there has been no replacement.

RECOMMENDATIONS: 1. A study should be conducted to investigate the best possible means of disseminating the educational information derived from cases discussed at our monthly meetings; e.g. (a) Meetings at rural and outer island hospitals. (b) Publication of case studies. (c) Cooperative efforts with a newly formed Continuing Education Committee for OB-GYN at the University of Hawaii School of Medicine. 2. The HMA president should appoint co-chairmen for this committee in the future. One should be an obstetrician to be in charge of reviewing all maternal deaths and the other, a pediatrician, to be in charge of reviewing all perinatal deaths.

FRANCIS M. TERADA, M.D.

Maternal and Perinatal Mortality Study

Your Committee then studied the report of the above committee. It feels that detailed case reports should not be a part of a committee report, but rather the subject of scientific papers. We do, therefore, recommend that paragraphs two, three, four, five, six, seven, and eight be deleted in their entirety and not become a part of the

proceedings of the House of Delegates. We also recommend deletion of the second and fourth sentences in the eleventh paragraph as they add nothing to the report. We also recommend changing the twelfth paragraph to read "since Dr. Roy Kaye's resignation in August, 1968, as chairman of the subcommittee which screens all perinatal deaths, there has been no replacement." We recommend adoption of the first recommendation except that the word "outer island" should be changed to read "neighbor island." We do not concur with the second recommendation and recommend that it not be adopted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MENTAL HEALTH

The committee this year continued to take an active part in the program of training in nonpsychiatric physicians in psychiatry. This was carried out by having members of the Mental Health Committee participate as members of a State Steering Committee composed of members of this committee as well as a representative from the HAGP. In addition to developing two courses this year, the State Steering Committee also received \$900 from the American Psychiatric Association for the purpose of having some physicians on the State Steering Committee observe other areas.

The committee also participated with the School Health Committee in helping develop a new sex education series in conjunction with the Department of Education.

The committee recommended that the Hawaii RVS unit value for psychotherapy (procedure #9050) be changed from 5.0 to 6.0.

A major portion of the committee's time this year took up two issues, namely: (1) whether nonpsychiatric physicians who occasionally do psychotherapy should be reimbursed for their services at the same level as psychiatrists and (2) whether or not psychologists should be reimbursed by prepaid medical plans or other insurance carriers for psychotherapy. A debate was held on both these issues in the committee itself and in joint meetings with the Hawaii Psychiatric Society. The committee also met with Dr. Jerome Boyer, President of the Hawaii Psychological Association, to obtain his views. As a result of this, the committee decided to submit three resolutions. The resolutions pertain to the following: (1) That all physicians who perform psychotherapy be reimbursed by HMSA and all other prepaid medical plans and insurance companies provided that letters of justification are submitted or psychiatric consultation is obtained. There was some debate on this latter point pertaining to letters of justification but the committee felt this would aid physicians in making clear to insurance companies why they are doing psychotherapy on any particular patient.

The third resolution pertains to whether psychologists, psychiatric social workers, and psychiatric nurses while working under the direction of a physician should be considered psychiatric paramedical personnel. It was felt that HMSA and all other insurance carriers should reimburse these practitioners when they are working under the direction of a physician.

There was much debate on the third issue, the major point of discussion being whether or not psychotherapy practiced by psychologists is the same as psychotherapy practiced by psychiatrists or other physicians. Regarding this, the issue was resolved by adopting the stand that psychotherapy could be done by people other than psychiatrists or other physicians if there is meaningful collaboration between the paramedical personnel and the physician. It was felt that training differs so much between psychologists and psychiatrists that psychotherapy by either of these two disciplines would be different. However, again it was felt that if the physician is made responsible for psychotherapy, it would be the

physician's responsibility to see that proper medical safeguards and treatment practice are retained.

This year, for the first time in many years, we had a representative at the Annual Conference of State Health Representatives, which is sponsored by the AMA. Dr. Leigh Sakamaki attended the 15th annual conference and reported back to the committee various highlights of the conference which focused on the mental health children.

Every spring the AMA sponsors a conference on mental health in Chicago. This conference has always been of great interest to specialists and nonspecialists in the field of mental health since it is at this conference that the general tenor and direction the AMA is taking is expressed. We believe it is important that Hawaii be represented at this conference not only to discuss what progress we have made, but also to gather ideas and to see how other associations are solving their problems. To this end we are requesting that this committee send one delegate with his expenses paid and so we request \$500.00.

BUDGET:

Travel expense \$500.00*

K. Y. LUM, M.D.

* Deleted by House of Delegates.

Mental Health

The Committee discussed the above report and feels that the fifth paragraph should be deleted and not become a part of the proceedings of the House of Delegates. We further feel that the budget of \$500 for travel expense is not indicated and should not be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

RADIATION

The year was spent primarily in preparing the bill proposed for limitations on application of radiation to humans. This was reviewed with the Legislative Committee where it was unanimously passed. Unanimous approval was also obtained from the Radiological Society of Hawaii. The proposed bill was expanded with definitions and also a statement of the scope or purpose. The bill was reviewed by the legal department of the State of Hawaii and was introduced in the Legislature. A statement and oral presentations at the hearings were given. The results of our efforts are not as yet known at the time of submission of this report.

X-ray and nuclear medicine equipment has become exceedingly complex, sophisticated, and at the same time a great deal more expensive. The Department of Health and the various State-controlled hospitals require the purchase of a great deal of such equipment. The Chairman of the Radiation Committee offered the committee's services as consultants and advisors in reference to the types of equipment and material that might be needed by the State, the evaluation of the needs for such equipment, and especially the requirements and specifications. This offer was accepted by Dr. Walter Quisenberry, Director of Health. It is the Chairman's suggestion that a subcommittee of radiologists and other types of physicians involved be formed whenever the Department of Health indicates that there is a need for advice.

The evaluation of the methods and progress made by the Department of Health's radiation and survey procedures has been postponed until next year.

There are no recommendations or budget requests.

GEORGE W. HENRY, M.D.

Radiation

The Committee discussed the Radiation Committee report and recommends its approval. It also feels that the chairman should be commended for his fine work at the

State Legislature in trying to establish radiation hazard standards for humans.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

SCHOOL HEALTH

The committee held monthly meetings regularly during the past year. There was good attendance. The committee set as its aims three basic areas of concern: (1) the development of active lines of communication and periodic meetings with officials of the Department of Health and Department of Education on matters related to school health problems; (2) the study of school health practices, services, and instruction, with the goal of improving existing practices or developing new ones; and (3) the development of methods of orienting members of the Medical Association about the profession's opportunities in school health and alerting them to better ways of working with school children, school personnel, and parents.

During the past year, the following areas of concern were taken up by the committee:

School Physician for the Department of Education: The committee has actively pursued the creation of the School Physician or a Director of Health Services for the school system. Dr. Donald Char chaired the Ad Hoc Committee to study the House Resolution of the last legislative session on creating a school physician. The committee has felt that this position is vital to the total development of a school health program in this state. It has felt that there is need to give over-all direction and implementation at this time to the school health program. Hopefully, the development of health coordinators and school nurses will follow the establishment of a school physician. The committee has felt strongly that health services, health education, environmental health, and special education for the handicapped child could be coordinated better with proper direction from a total school health service program.

Family Living and Sex Education. A subcommittee chaired by Dr. William Moore, Jr., with Roy Kuboyama and Michael Hase organized a pamphlet with references of educational material and films on family living and sex education. This is to be distributed to all practicing physicians in the State and will be available to the community and schools. The Churchill films "Girl to Woman" and "Boy to Man" were received from a Chamber of Commerce grant and placed in the Department of Health library for public use.

In addition to the above, the committee was actively involved in the educational TV production, "It's Your Health," a local production on family living and sex education for high school students. A series of videotapes were produced using HMA physicians. The committee also assisted the Department of Education in the introduction of educational TV series, "Time of Your Life" for fifth and sixth graders. Members of the committee have been representatives on the Review Board of the Department of Education's family living and sex education programs.

School Health Exhibit. A very successful three-day Health Fair was held in Honolulu in October, sponsored by the Honolulu County Medical Society. A subcommittee chaired by Dr. Stephen Tenby with Raymond Wong and Fred Pope organized a School Health Exhibit, dramatizing the total care of the child in school and his health. This promoted a better understanding on what school health is to the community.

School Athletic Program. Discussions were held with the coordinators of the Department of Education on the total school athletic program, intra and extramural. The committee adopted and will circulate to the membership a list, "Disqualifying Conditions for Contact and Non-contact Sports."

Drug Addiction Program. The committee explored the possibility of establishing a "Teen Challenge" program

with the Mental Health Association for the public schools. It is hoped that a pilot program can be initiated soon.

School Health Forms. The committee maintained the current Department of Health's Form 14 and suggested that school exams be performed annually during the child's birthday month. The committee also felt that this examination was sufficient for competitive sports.

Unwed Mothers and Schools. The committee reviewed the current school handling of unwed mothers. The Department of Social Services presented some of the current problems and solutions in the State. A special class is held on the Island of Oahu for mothers and they are encouraged to continue their education following delivery. The total problem of health education and family living relates again to an over-all concern in developing a total program from kindergarten through twelfth grade in the school system.

No separate budget request is being made.

RECOMMENDATIONS: (1) That the HMA continue to support the DOE in the development of a family living and sex education program from kindergarten through 12th grades with the endorsement of the film series "Time of Your Life" and the locally produced series, "It's Your Health." (2) That the HMA mail to the practicing physicians periodically the new "Disqualifying Conditions for Contact and Noncontact Sports" developed the past year and also include in the mailings the public health regulations governing communicable disease regulations in schools. (3) That the HMA support the current legislative proposal for the school physician through the Department of Health with a recommendation that it somehow be implemented into the Department of Education in the near future. 4. That the HMA endorse and support the concept of health coordinators and school nurses and suggest that these workers be under the direction of the proposed school physician or Director of Health Services. (5) That the HMA actively study recent demands for government involvement in school health programs locally.

CALVIN C. J. SIA, M.D.

School Health

The Committee then discussed the School Health Committee Report. Dr. Quisenberry gave considerable background information on the use of school health forms. The Committee endorses the recommendations of this committee except number three. It feels that the HMA should support current legislative proposals for the School Physician through the Department of Health and so recommends.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WATER SAFETY

The committee did not meet during the year. Communication with the water safety commission of the City and County resulted in no direct action as the program of the new administration is still being formulated. The standing offer by the committee chairman to cooperate in any way necessary was made, and accepted by the Mayor's representative.

No budget request nor recommendations are made at this time.

ARNO J. MUNDT, M.D.

Water Safety

The Committee next considered this report and noted the committee had not met.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON PUBLIC HEALTH

The report of the Commission on Public Health is embodied in the reports of its various committees. The organization and functions of these committees are a credit to the HMA, and the work accomplished is a credit to the members and chairman of the committees.

It is interesting to note the changing nature of the work of the committees of the Public Health Commission from that relative to dealing with specific diseases, to that dealing with healthful living, both environmental and mental. The time and energy concerned with the development of rubella vaccine usage in 1969 is insignificant compared to polio vaccine effort of this Association in 1961-62. This year Automotive Safety, School Physician, and Sex Education have been among the Commission's principle concern.

There are no recommendations for changes in the structure of the commission nor in its various committees: budget requests are contained in committee reports.

JOHN R. STEPHENSON, M.D.

Report of the Commission on Public Health

The Committee next considered this report, concurred in its implications, and noted that the commissioner does not recommend any changes in the structure of the commission.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

Resolution No. 9

The Committee considered this resolution concerning the sale of cigarettes within hospitals and clinics throughout the State. The Committee recommends that the resolution be not adopted at this time because of the fact that many physicians still smoke and this is inconsistent with the resolution.

ACTION:

It was pointed out that the intent of this resolution is good and the fact that many physicians still smoke is not a valid reason for not adopting the resolution. It was moved and seconded to adopt the resolution. It was voted to adopt the resolution.

RESOLUTION NO. 9 AS ADOPTED

Re: Sale of Cigarettes

WHEREAS, The Hawaii Medical Association has previously taken into consideration the danger of cigarette smoking to health in its Resolution Number 3, adopted at the 1964 Annual Meeting, and in its Resolution Number 10, adopted at the 1966 Annual Meeting; and

WHEREAS, The number of deaths per year directly or indirectly related to cigarette smoking continues to be increasingly alarming; and

WHEREAS, The Surgeon General's Task Force on Smoking and Health has recently issued a report calling on members of the medical profession to set an example for the public; and

WHEREAS, The physician must stand together with all health personnel and health institutions in combating public health problems and promoting the general good health of the nation; and

WHEREAS, The collective position of members of the medical profession on the problems of cigarette smoking and health must be perfectly clear and consistent; and

WHEREAS, The physician should set a personal example regarding the health hazards of smoking; and

WHEREAS, The medical profession should pursue any measure that will contribute to demonstrating concern in the form of a firm public stand on the hazards of cigarette smoking; and

WHEREAS, The availability of cigarette vending machines in health institutions is a sign of inconsistency and

indicates to the public that physicians are not sufficiently concerned that cigarettes are ravagers of health; now therefore be it

Resolved, That this House of Delegates to the Hawaii Medical Association, now in annual session this May of 1969, recommend that efforts be made to discontinue the sale of cigarettes within hospitals and clinics throughout the State of Hawaii, and further recommend to the medical executive staffs of all hospitals and clinics that they work toward the end of discontinuing cigarette sales within their respective institutions.

Submitted by GEORGE W. HENRY, M.D.

Resolution No. 13

The Committee considered the resolution on tetanus toxoid reactions which has been strongly endorsed by the Academy of Pediatrics and others.

ACTION:

The Chairman recommended that Resolution No. 13 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 13 AS ADOPTED

Re: Tetanus Toxoid Reactions

WHEREAS, An increasing number of tetanus toxoid reactions are being reported; and

WHEREAS, Recent tetanus antibody titer studies show that the interval of protection after four or more injections is greater than 12 years from the last injection; now therefore be it

Resolved, That the routine immunization schedule suggested by the American Academy of Pediatrics be adopted and that when there is a valid history of the routine schedule of immunization outlined, special tetanus boosters on admission to camps, schools, and colleges be abandoned.

Reference: Peebles, T. C., Levine, L., Eldred, M.D., and Edsall, G.: New Eng. J. Med. 280, 575-581, 1969.

Submitted by WILLIAM F. MOORE, JR., M.D.
Endorsed by the SCHOOL HEALTH COMMITTEE
also by the COMMUNICABLE DISEASE AND
IMMUNIZATION, TB & VD COMMITTEE

Resolution No. 6

Your Committee recommends adoption of this resolution with the following revision of the third whereas to read "We feel that those clinical psychologists working under the supervision of a physician should be recompensed by medical insurance programs." We further recommend that the resolved be revised to read "That this implies that the basic responsibility for the patient is carried by the physicians and clinical psychologists work under a physician's orders. . . ."

ACTION:

The Chairman recommended that Resolution No. 6 be adopted as revised. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 6 AS ADOPTED

Re: Payment for Psychiatric Services Performed by Paramedical Personnel

WHEREAS, HMSA and other insurance companies provide payments for medical services; and

WHEREAS, We do not question the matter of anyone's receiving payments for providing medical services; and

WHEREAS, We feel that those clinical psychologists working under the supervision of a physician should be recompensed by medical insurance programs; therefore be it

Resolved, That this implies that the basic responsibility for the patient is carried by the physicians and clinical psychologists work under physicians' orders, and while

doing this, such personnel should be reimbursed by the insurance carriers.

Submitted by the MENTAL HEALTH COMMITTEE

Resolution No. 8

Your Committee studied the resolution relating to payment for psychiatric services for nonpsychiatrists. Although we have some strong reservations about this matter, we support the intent of the resolution and recommend its adoption.

ACTION:

The Chairman recommended that Resolution No. 8 be adopted. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 8 AS ADOPTED

Re: Payment of Nonpsychiatric Physicians for Psychotherapy

WHEREAS, It is our belief that all physicians should be encouraged to perform psychotherapy and to increase their skill in this area; now therefore be it

Resolved, That all insurance companies be encouraged to reimburse nonpsychiatric physicians for providing supportive psychotherapy to patients when the need is indicated and where the time spent is over and above the normal patient visit, provided letters of justification are submitted or psychiatric consultation is obtained; and be it further

Resolved, That after two years, the Psychiatric Society and the Mental Health Committee of the Hawaii Medical Association review the experience of the HMSA and other insurance carriers which have added this benefit to their programs.

Submitted by the MENTAL HEALTH COMMITTEE

ACTION:

The Chairman moved adoption of this report as a whole as amended. It was adopted.

PARLIAMENTARY AFFAIRS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and gave careful consideration to the matters referred to it. The Committee is pleased to make the following report:

COMMISSION ON LEGISLATION

During the past year there has been a gratifying increase in interest in the process of legislation by members of the Association. The chairmen or members of the various committees which have referred problems that need legislative action have been most cooperative in the preparation of bills and subsequent support in preparing testimonies and presenting these testimonies to the various committees of the Legislature. In the process, many members have spent many hours away from their own practice of medicine for the good of the community. As partial reward for some of these sometimes thankless tasks, these individuals have learned some of the intricacies of the legislative process and legislators have made favorable comments regarding their efforts.

It is a known fact that killing a bill is much easier to accomplish than to maneuver a bill favored by the Association for passage. For this reason careful preparation of a bill is necessary and all the objections that may arise against a bill must be anticipated and if possible overcome prior to a confrontation at a public hearing of the Legislature. Such a confrontation sometimes is unavoidable if a compromise cannot be reached; but an effort should be made, if possible. As an example, consider the preparation of a bill to require osteopathic

physicians and MD's to take the same licensing examination. We know that the motivation of those who want such a law is the protection of the public from poorly educated and trained practitioners. In addition, this approach, if worked diplomatically, will establish a closer, more harmonious relationship with the osteopaths as recommended by the House of Delegates of the AMA. But will we be able to convince the legislators of these facts if equally reputable osteopaths disagree with us?

Members of the Association who are impatient must realize that having a bill enacted is arduous, time consuming, and often frustrating. We ask their indulgence and cooperation, because we as an Association should not if possible use the "hard sell" approach as some organizations with greater power to influence the voters can do. Many times the "soft sell" approach can accomplish when the "hard sell" will fail. Of course the "soft sell" approach will mean a great deal of effort on our part to convince legislators of the merits involved in our proposals. In addition it must be emphasized that merit alone is insufficient to obtain favorable action for or against certain bills. In this process, compromises must be made in areas that may not meet with the approval of many members of the Association. Occasionally, it is prudent not to take a stand on certain bills which are highly charged politically, even though medical issues are involved because our voices may make very little difference in the outcome anyway.

The above examples are some of the trials and tribulations of those of us who are involved in lobbying activities at legislative bodies. Anyone in the Association who wishes to become involved should make his wishes known.

GEORGE GOTO, M.D.

Commission on Legislation

Your Committee first considered the report of the Commission on Legislation and recommends that the report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BUREAU OF RESEARCH & PLANNING

The Bureau worked closely with Dr. Paul J. Sanazaro in establishing a preliminary study of the quality of health care delivery in hospitals in Hawaii. Dr. Sanazaro's report was published in the July-August, 1968, HAWAII MEDICAL JOURNAL, thereby receiving wide dissemination. Recommendations included a voluntary definitive study of physicians' services in offices and hospitals as a basis for improving the quality of care and for planning continuing education programs.

Much of the Bureau's efforts since then have focused on the problems involved in implementing the suggestions of Dr. Sanazaro. Dr. Richard Mamiya, as chairman, established the study of priorities in this area as the first order of business. In December, Dr. Oren assumed the chairmanship and, at the January Council meeting, reported the Bureau's recommendation that a poll of the HMA membership re office audits be undertaken. The Council accepted the Sanazaro report in principle and recommended that first steps be initiated.

Since that time members of the Bureau have met on several occasions with representatives of consumer organizations (jointly with the Public Relations Committee) to discuss problems of health care delivery and costs. The chairman has attended several conferences relating to these problems, including ones on the mainland sponsored by the Pediatric Academy and by the AMA, as well as those locally including the recent Hawaii Conference on Health Care Costs (April 21-22). In addition there has been much discussion in recent Bureau meetings with Dr. Robert Mytinger of the University of Hawaii School of Public Health re a proposed Center for

Health Services Research and Development, which might be set up as an inter-agency local resource to coordinate projects in these areas. It is important to note that Dr. Sanazaro is now Director of the National Center for Health Services Research and Development in Washington, D. C.

In other related areas the Bureau has initiated liaison with the Comprehensive Health Planning Agency of the Hawaii Department of Health and with the Regional Medical Program, in order to maintain an overview of new health projects. The previously initiated study of HMA organization is now under the direction of Dr. Iaconetti.

RECOMMENDATIONS: (1) The Bureau should pursue implementation of the recommendations of Dr. Sanazaro, initially by developing a mechanism, acceptable to the HMA membership, for the study of office care in Hawaii. (2) Further efforts should be made by Bureau members to "keep abreast of the times and prepare the Association to meet future challenges" as initially stated by the House of Delegates in forming this Bureau. This should involve close contact with all activities in the area of health care delivery within the community. (3) The Bureau should become an effective resource agency to the President and the Council in the entire area of medical, social, and economic change.

JOSEPH OREN, M.D.

Bureau of Research and Planning

Your Committee next considered the report of the Bureau of Research and Planning. A full and complete discussion of the subject was had and the Committee recommends approval of all the committee's recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE

The committee held its first meeting on September 5. It met weekly during the legislative session and each meeting was well attended by the members of the committee. Perhaps never in the history of the Legislative Committee has there been more active participation than during this session. Committee members testified at 39 hearings in the various House committees and at 18 Senate hearings. There were countless hours spent in preparation of testimony and private lobbying sessions with key legislators. Bills were assigned to the various committee members for their review and discussion. Lengthy discussions were held regarding the franchising of hospitals, a common board for osteopaths and medical doctors, and amendments to Act 97. It was the decision of the Legislative Committee to take no stand on these matters at the present time.

The DSS Budget item was of interest to the committee in that the HMA had requested a change in the conversion factor from 5 to 6. The House Finance Committee report indicated a "tight hand" on the DSS budget and offered no special consideration of the HMA request. The House also deleted the position of School Physician from the Department of Health's budget request. The Senate, however, indicated that the DSS should be given flexibility to negotiate with HMA for a satisfactory settlement. They also included the position of School Physician in their version of the budget. At the present time, the Conference Committees are battling out the budget requests and it would appear that no action will be taken until the very final day of the session. It would also appear that the battle of the budget might very well cause an extension of the present 60-day session.

The Legislative Committee had introduced bills relating to a State Medical Examiner System, a "Good Samaritan" bill, and a bill limiting the application of

radiation (excluding chiropractors). The fate of the State Medical Examiner system is unknown at the present time. It has passed through the Senate but must still go through second and third reading in the House. A "Good Samaritan" bill will undoubtedly pass through both houses (HB 58) and even though it is not the bill which we introduced, the bill receives the full support of the HMA. The radiation bill, as was anticipated, was a very "hot" item. The chiropractors bitterly opposed the bill. In spite of the fact that both the Senate and House version of the radiation bill appears to be "dead" for this session, it was a very educational experience for all concerned.

As this report is being written, the legislators are entering the final days of the legislative session. We will not know the outcome of the various bills in which we are particularly interested for another week or so but we can foresee that many of those on which we testified in favor will pass this session. In the Senate there were 1,129 bills introduced. Of these, approximately 80 bills pertained to health. There were 1,259 bills introduced in the House this session, of which 97 pertained to health. Both the abortion bill and the fluoridation bill have died in committee.

Mr. Clesson Chikasuye has proved to be a worthy successor to Mr. Roy Takeyama as our legislative counsel and he has been an invaluable aid to the Legislative Committee in obtaining favorable action on bills favored by the Association and to have bills which would be harmful to good health care of the public tabled.

The Chairman also acknowledges the invaluable service rendered to the Legislative Committee by our secretary, Mrs. Becky Kendro, who has kept the committee informed in a most laudable manner on all bills and resolutions of special interest to the Association. Without her dedicated assistance in preparing testimonies for the 57 hearings that the members of this Association participated in, the good rapport that the Legislative Committee has established over the years with the Legislature would have been difficult indeed to maintain. Her salary is not shown as a separate item in the budget request as it has been incorporated into the operating budget.

BUDGET REQUEST:

Counsel	\$6,000.00
Dinner and entertainment.....	1,000.00
Today's Health	150.00
Miscellaneous	100.00
TOTAL.....	\$7,250.00

RECOMMENDATIONS: (1) That the invaluable services of Mr. Clesson Chikasuye be acknowledged and that his services be extended for the next session of the Legislature in 1970. (2) That Mrs. Becky Kendro continue to be assigned to the Legislative Committee indefinitely.

GEORGE GOTO, M.D.

Legislative

Your Committee next considered the report of the Legislative Committee. A full and complete discussion was held. Your Committee recommends approval of the budget request of \$7,250.00 and recommends approval of the committee's recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGISLATIVE COUNSEL

As this report is being written, the Legislature is still in session and in its 60th day. There are indications that an extended session may be necessary in order to resolve the differences that exist between the Senate and the House relative to the budgets, both operating and capital, and the governmental pay raises. In view of this

situation, the outcome of bills in which the Hawaii Medical Association is interested, is to a large extent unknown.

There were 1,129 bills introduced in the Senate. Of these, approximately 80 bills were health measures. There were 1,259 bills introduced in the House. Of these, approximately 97 bills were health measures. A detailed analysis of the bills at this time is not possible for two reasons: (1) the Legislative Session has not ended and (2) insufficient time has been allotted for the preparation of a comprehensive report, due primarily to the fact that the House of Delegates will convene shortly.

Following are a few of the more noteworthy bills in which the Association has an interest.

Anatomical Gift Bill: The purpose of this bill is to authorize the donation by a person or his next of kin of all or part of his body for medical, educational, or scientific purposes. Such gifts would help to meet the need for cadavers and the need for organs or tissue banks or transplants. This bill has passed both houses and awaits the Governor's signature.

Good Samaritan Bill: The purpose of this bill is to provide immunity from civil damages to any person, including doctors, who voluntarily and in good faith renders emergency care to a victim of an accident or emergency. Such immunity, however, does not extend to civil damages resulting from gross negligence or wanton acts or omissions. This bill has passed both houses and awaits the Governor's signature.

Blood Transfusion a Service and Not a Sale: The purpose of this bill is to make blood transfusion a service and not a sale, in order to get away from the warranties that accompany a sales transaction. The Blood Bank representatives testified that their primary objective was to be relieved from the implied warranty that blood was free from the virus of serum hepatitis for which there is no known scientific test at present to detect the presence of such virus. This bill was amended by the Senate in order to meet the primary objective of the Blood Bank people. Accordingly, any reference to "sale" or "service" in the bill was eliminated and the bill provides that no implied warranty exists that the blood is free from the virus of serum hepatitis. This bill has passed both houses and awaits the Governor's signature.

Professional Corporations Bill: The purpose of this bill is to permit professional persons, including doctors, to incorporate. By incorporating, professions are able to take advantage of the tax benefits resulting from doing business as a corporation. The tax benefit resulting is the ability to create pension and profit sharing plans. This bill has passed both houses and awaits the Governor's signature.

Qualifications of Health Director: The purpose of this bill is to delete the present qualifications that are required for the Director of Health. This is an Administration bill and its primary objective was to provide greater flexibility to the Governor in the selection of the Director of Health. Due to the efforts of the Association, this bill was amended several times with the last amendment providing that the Director of Health must be a licensed physician. The other qualifications have been deleted. This bill has passed both houses and awaits the Governor's signature.

Abortion Bill: The purpose of this bill is to permit abortions in three instances: (a) where the health of the mother is endangered; (b) where the child may be born with a defect, and (c) where pregnancy resulted from rape. This bill passed the House but failed to pass the Senate.

Medical Examiner Bill: The purpose of this bill is to establish a statewide Medical Examiner System and a Medical Examiner Commission within the Department of the Attorney General. This bill passed the Senate but failed to pass the House.

Several bills were introduced this year that would give a licensed physician hospital privileges in any hospital within the State. Fortunately, none of them has passed. I believe that similar bills will be introduced in the future, and suggest that the Medical Association, and the Hospital Association pool their efforts in this regard.

There are two items in the Operating Budget which affect the Association. The first item is the creation of a School Health Physician position and the second item is the increase of conversion factor for the DSS fee schedule from 5 to 6. At this time, indications point to the approval of the first item and denial of the second item. I suggest that the Association accumulate detailed facts, including cost projections and reasons in support of the proposed increase in the conversion factor, for submittal to the State Department of Social Services prior to the next legislative session.

The Association has attained stature and rapport with the members of the Legislature. I believe this is largely due to (1) the effective work and leadership of Dr. George Goto, Chairman of the Legislative Committee, (2) the cooperative efforts of all of the members of the Legislative Committee, and (3) the practice of various members of the Association appearing at hearings before legislative committees. I believe this stature and rapport will increase if the Association continues its efforts in this direction. May I, however, add one bit of caution. It is imperative that the members of the Association work through the Legislative Committee, and not around or behind the Legislative Committee. The Legislative Committee knows the pulse of the Legislature through its frequent contacts and is most qualified to know where restraint should be used and where pressures should be applied. For the members of the Association to lobby on their own, no matter how well their intentions may be, invites damage and injury to the goals and objectives of the Association.

I wish to take this opportunity to thank the HMA for giving me this opportunity to serve the Association. I also wish to thank all of the members of the Legislative Committee for their support. My sincere appreciation and thanks to Dr. George Goto for his excellent leadership and cooperation. It was a real pleasure to work with all of you.

CLESSION CHIKASUYE

Legislative Counsel

Your Committee next considered the report of the Legislative Counsel and a full and complete discussion was had. We recommend that the report be accepted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

BYLAWS AND PARLIAMENTARY

The committee received no mandates from the House of Delegates nor were any matters referred to it prior to the 60-day deadline established for proposing changes in Bylaws. At the 1968 annual meeting it was suggested that the two largest commissions might be split into four smaller commissions. However, neither the Commissioner on Public Health nor the Commissioner on Public and Interprofessional Relations requested the committee to study this matter. Neither was a request received from the Bureau of Research and Planning, which has a subcommittee that is making a study of the over-all organization structure of the Association. The Reference Committee suggested a restriction be placed on the Council that would prohibit the Council from approving any nonemergency, unbudgeted expenditure in excess of \$500. There was no definition of "nonemergency" and no mandate that this be written into the Bylaws.

It was noted that the reference in the Bylaws to the Council as the Finance Committee was not deleted by House action at its last meeting. No meeting was called to make this correction as it was felt that it was so minor, the change could be made the next time Bylaw amendments are proposed.

Subsequent to the 60-day deadline for submitting proposals for Bylaw changes, several matters were referred to the committee for clarification. It met on May 15 and reached the following conclusions.

Article VI, Paragraph 3, of the Charter was amended in 1968 to read: "The Council shall be composed of the President, the immediate Past President, the President-elect, the Secretary and Treasurer of the corporation, the Delegate and the Alternate Delegate to the American Medical Association, and such number of additional Councilors as shall be provided for in the Bylaws..." Through inadvertence, similar change was not made in that Chapter of the Bylaws which covers the Council. Therefore, the Bylaws do not state that the Delegate and the Alternate Delegate to the American Medical Association are members of the Council. This addition was made in the change amending that portion of the Bylaws which sets forth the make-up of the House of Delegates. It is the opinion of the Bylaws and Parliamentary Committee that this omission in the Bylaws was an inadvertent clerical error, that the Charter takes precedence over the Bylaws, and that the seating of these officers at the meetings this past year has been legal and that the seating of these two officers at future Council meetings and until such time as this error can be corrected will continue to be legal and proper.

The President-elect asked for clarification of his duties as they relate to nominating members to the Finance Committee. Chapter III, Section 5 (2) states that the "President shall appoint all committees except the elected committees provided for in Chapter VIII." Chapter VIII Section 1 states "The President shall designate the chairman of each committee except the Nominating Committee and the Finance Committee." Section 13(b) states "The Finance Committee shall consist of the Treasurer of the Hawaii Medical Association, the treasurer of each component society, and five other members, who shall be elected by the Council from nominees presented by the President of the Association. The chairman shall be the Treasurer of the Hawaii Medical Association." Chapter VIII, Section 2 states "...The President shall by appointment fill all vacancies on all standing and special committees and commissions of the Association, except the elected committees. Appointments shall be for three years on a staggered basis. The Nominating Committee shall be elected by the House of Delegates, and the Finance Committee and the Bureau of Research and Planning shall be elected by the Council from a list of nominees submitted to it by the President."

Two of the five "other" members of the Finance Committee have terms expiring with the coming annual meeting. It is the opinion of the Bylaws and Parliamentary Committee that it is incumbent upon the president to nominate two physicians to fill these vacancies. In the case of the Bureau of Research and Planning, the terms of five of its members expire with the coming annual meeting. It is the opinion of this committee that inasmuch as the Bylaws do not specify a maximum number of members for the Bureau that the President may nominate as many physicians as he wishes to serve on the Bureau for the required three-year terms, notwithstanding the requirement "four being elected each year."

This committee was also asked for an opinion on the right of dues-delinquent members to register and participate in activities that take place during the annual meeting. Chapter IX, Section 3, of the Bylaws states "A member is delinquent if his dues for any year are not received by the Association by April 1 of that year and shall automatically forfeit his membership in the Association if he fails to pay the delinquent dues within 30 days after the notice of delinquency has been mailed by the Secretary of the Association..." Chapter VI, Section 5 (a) and (b) read "Each member in attendance at the Annual Session shall enter his name on a registration form, indicating the component society of which he is a member. When his right to membership has been verified and he has paid his registration fee, he shall receive a badge. No member shall take part in any of the proceedings of the Annual Session until he has complied with the provisions of this Section." At its last meeting the Council voted to delay sending out delinquency no-

tices until further efforts to collect the 1969 dues were made. It is the opinion of this committee that members who are delinquent are members not in good standing. Chapter VII, Section 1(a) "Any active member shall be eligible for election or appointment to any office of this Association if he is an active member in good standing at the time of election and has been an active member of this Association for at least three consecutive years immediately preceding his election or appointment." The Bylaws are silent on the eligibility of members not in good standing to serve once elected. They are also silent on the eligibility of a member not in good standing to register for the annual meeting. It is the opinion of the Bylaws and Parliamentary Committee that members not in good standing by reason of dues delinquency are not eligible to register for annual meeting activities or to be seated as delegates or officers of the Hawaii Medical Association. They may either register as guests or pay their dues prior to registering as members.

RECOMMENDATIONS: (1) That the next Bylaws and Parliamentary Committee be requested to review Chapter V of the Bylaws and correct the inequities, the proposed corrections to be circulated as required in order that action can be taken by the House of Delegates when it is next in session. (2) That the next committee be requested to examine those portions of the Bylaws which are silent on eligibility of delinquent members to vote and participate in the annual meeting activities. (3) That if it is the wish of the House that the Council be restricted from authorizing expenditures in excess of \$500 of the amount budgeted, that it set forth some guidelines for the next committee to use in developing this Bylaw proposal. (4) That the Bureau of Research and Planning be reminded that its subcommittee that was assigned the task of studying the HMA's organization structure, communicate its findings to the next committee if Bylaw changes are to be proposed, keeping in mind the 60-day deadline. (5) That the manner of constituting the Bureau of Research and Planning be restudied. (6) That the definition of the Finance Committee be restudied with the idea of specifying the length of the appointments and setting forth the duties of the committee.

HARRY L. ARNOLD, JR., M.D.

Bylaws and Parliamentary

Your Committee next considered the report of the Bylaws and Parliamentary Committee. A full and complete discussion was had and your Committee recommends approval of all the committee's recommendations and that with regard to Recommendation No. 3, the Bylaws Committee prepare an amendment to the Bylaws for presentation to the House of Delegates at its next annual meeting which would restrict the Council from authorizing unbudgeted expenditures in excess of \$500, and your Committee further recommends that this proposed amendment become the policy of the Council for the ensuing year.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NATIONAL LEGISLATION

In conformity with the recommendations and established practice of the previous National Legislation Committee, this committee made arrangements to have separate meetings with our representatives in the U.S. Congress and their staff despite the limitations imposed upon them by the 1968 election and campaign and their busy 1969 schedule.

During our meeting with Representative Spark Matsunaga he explained in great detail the procedural system in the passage of a bill. In addition, he gave the group some background information on HR 2767, a bill to reduce the amount of matching funds provided for the

Title XIX program. The HMA Council subsequently voted to oppose such Congressional action.

The highlight of our meeting with Representative Patsy Mink was the national problem of illegal drug usage. She emphasized the point that the medical profession is being looked to for leadership in designing programs to reduce the incidence of this national problem.

The meeting with Senator Fong gave the committee additional insight into the workings of Congress.

We have maintained a continuous flow of correspondence with our Congressmen since the meetings were held in order to keep them as informed as possible of our activities and opinions.

The committee encouraged support of legislation that would nullify the IRS regulation to tax journal income. Although the AMA may receive some form of tax, it has been speculated that the HMA JOURNAL will be exempted.

There were 23,000 bills before the 90th Congress, of which 1,400 were of medical orientation. Five hundred health-related bills have been introduced thus far during the First Session of the 91st Congress.

Members of Congress are going to have their hands full reviewing the existing health programs due to expire at the end of fiscal 1970. Just to mention a few:

Hill Burton, Comprehensive Health Planning and Services, Heart Disease, Cancer and Stroke Program (Regional Medical Program), Health Research Facilities Construction Act, Clean Air Act, Mental Retardation Facilities Construction Act, Medical Library Assistance Act, Alcoholic and Narcotic Addict Rehabilitation Amendments, Solid Waste Disposal Act, Health Services for Migratory Agricultural Workers Amendments, Health Services Research and Development Amendments, and many, many more.

In our favor is that fact that Mr. Herbert Cornuelle, former Chairman of the Board of Regents, has been selected a member of the advisory group or brain trust of HEW Secretary Robert Finch. We are under the opinion that he will undoubtedly look after our welfare.

The committee considered and took action on the following bills introduced during the First Session of the 91st Congress:

BILL	POSITION	DECISION
	Bills nullifying IRS regulation to tax JOURNAL income.....	supported*
HR 4015	Generic formulary under Federal Health programs	opposed*
	32 bills designed to include chiropractic services under federal health programs.....	opposed**
S 110	Expansion of Medicare program	opposed
S 111	Reasonable allowance for physicians services	opposed
S 1195	Reasonable Cost under Part A—Medicare	opposed

* Congressmen notified of position.
** Sent copies of HEW Report which recommended chiropractors not be included under Medicare.

Note: It should be remembered that the HMA has an official position on many legislative items introduced during previous sessions of Congress. The National Legislation Committee has been guided by those policies.

This committee would like to commend the Council of the Hawaii Medical Association for establishing the much needed position of Director of Public Affairs.

There is no budget request.
RECOMMENDATIONS: (1) That the National Legislation Committee continue to develop a strong liaison with Hawaii's representatives to Congress and members of their staff. (2) That the physicians of Hawaii take an interest in and provide leadership for programs concerning federal medical legislation.

CESAR B. DE JESUS, M.D.

National Legislation

Your Committee next considered the report of the National Legislative Committee. A full and complete discussion of the report was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL PRACTICE ACT

The committee had numerous issues that were referred to it and I need only review a few of the more important issues. SB 809 makes the following change. At the present time, the Board of Medical Examiners examines the qualifications and determines whether an applicant is ready for licensing and recommends to the Department of Health that a license be issued. However, if SB 809 does become law, the Board of Medical Examiners will not only do what is stated above, but it would also issue licenses to doctors and would have the authority of revocation or suspension of licenses in this State. In other words, the Board of Medical Examiners would have regulatory powers which they do not have at present.

The committee was assigned the duty of passing legislation which would require that both medical and osteopathic physicians be required to pass the same examination. The committee had many meetings and also met with Dr. Alan R. Becker, who is the President of the Osteopathic Association. From these meetings, the committee got the impression that, although the American Medical Association on a national basis is all for integrating the osteopaths into the field of medical care, the Osteopathic Association evidently is not too enthused about this integrated program. After these exploratory meetings with the osteopathic spokesman, we reviewed with the Legislative Committee methods to approach this problem. The Legislative Committee felt that it would be best that we try and work out a law that can be acceptable to both the osteopaths and the medical profession. It was the consensus of the Legislative Committee that without the cooperation of the osteopaths, any unilateral bill introduced by the Hawaii Medical Association would be dead. We are now in the process of working out legislation with the help of the Attorney General to develop such a law.

I wish to thank all the members of my committee for their untiring efforts.
There is no budget request.

B. ALLEN RICHARDSON, M.D.

Medical Practice Act

Your Committee next considered the report of the Medical Practice Act Committee. There was considerable discussion regarding foreign physicians. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

LEGAL COUNSEL

This report covers the period from April 1, 1968, through March 31, 1969.

Your counsel attended, at your expense for travel and without charge for time, the one-day seminar for Medical Societies Executives and Attorneys, and the two-day seminar on Medical Ethics, at AMA offices in Chicago in October of last year.

All meetings of the Council of Hawaii Medical Association were attended by counsel. There was time spent on HMA-HMSA negotiations which, as is generally known, did not result in change in the status of the relations between the two parties, although the Attorney Gen-

eral's office called after the first of the year indicating that office was still reviewing the antitrust aspects of HMA's minimum contract requirements proposed long ago. There was a certain amount of activity with reference to the Workmen's Compensation Committee which again did not result in any major changes in the relationship of the parties. There was some small action with reference to a threatened suit by Unigraphic. We had administrative inquiries with reference to the Tumor Registry, some queries with reference to legislation, and miscellaneous administrative matters.

Your counsel has no recommendations.

V. THOMAS RICE

Legal Counsel

Your Committee next considered the report of the legal counsel. A full and complete discussion of this report was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE TO IMPLEMENT HR 53

The committee met on four occasions since its inception last July, 1968.

This committee has been considerably frustrated by an inability to deal with the people and agencies directly concerned with HR 53. HR 53 charges the State Departments of Education and Health to jointly study the area of health programming, involving services as well as education, for the Department of Education, and nowhere was it specified that physicians in practice should be involved or consulted.

Therefore, the entire year was spent pursuing people related to this subject in an attempt to have them do something constructive regarding HR 53. To my knowledge, no one ever sat down to study the resolution and the Department of Education report to the Legislature clearly showed that the actions taken continue to be piecemeal efforts and totally fragmented and disjointed attacks on the entire problem.

The entire committee met in July, November, and December, 1968, and finally in March, 1969.

The Chairman attended the sessions sponsored by DOE in regard to the visit of Dr. John Lampe of the Denver School District who came out as a consultant to DOE for the school health program. Illustrative of the difficulties in dealing with this area is the fact that the formal report of Dr. Lampe was never released to our committee until it was directly requested for our last committee meeting in March, 1969.

In July, the chairman saw Mr. Ralph Kiyosaki concerning this matter. Whether coincident or not, in August, funds were set aside by DOE to create the position of a school physician to be hired by the State, but to be administered by the Department of Health.

At the time of this writing, the recruitment for the position remains unfulfilled. According to administration plans, and the budget request for FY 1969-70, a position has been created within the Health Department under the Children's Health Services, but lateral to crippled children and maternal and child health programs, for a school physician. Unfortunately, at the time of this writing, the House Finance Committee has deleted this position from its budgetary recommendations, and provided for a \$10,000 study. Some effort to restore this position in the Senate version of the budget must be made if we are to retain the school physician concept within the governmental structure.

Parenthetically, it must be recorded that this committee favors the school health physician's being placed in the DOE hierarchy rather than in the Department of Health. However, rather than oppose the budgeted position, it was felt that it would be more advantageous to first fund the position by our Legislature, and then work

with the position to see how it could best be developed for optional function once it is budgeted.

This committee has no specific recommendation for continuing its activities other than to point out the continuing need to remind the Department of Education to better coordinate and manage its over-all health programs, both for the students and the faculty. These functions should be adequately met through the School Health Committee.

DONALD F. B. CHAR, M.D.

Ad Hoc Committee to Implement HR 53

Your Committee next considered the report of the Ad Hoc Committee to Implement HR 53. A full and complete discussion of this report was held. Your Committee recommends approval of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AMA DELEGATE

In 1968 the annual meeting of the AMA was held in San Francisco, California, and the clinical session was held in Miami Beach, Florida.

Of particular interest during the year were changes in personnel and in the functions of the AMA staff. Following the resignation of Dr. Bing Blasingame, who had been Executive Vice-President for many years, the Board of Trustees unanimously appointed Dr. Ernest B. Howard as Executive Vice-President. Dr. Howard had been Assistant Executive Vice-President for a number of years. Also of interest was the combining of the field service and the political action divisions of the AMA staff into one group. It is thought that this will improve efficiency of these divisions. In the future, one person will act as the field service representative as well as the AMPAC representative.

Of interest to us in Hawaii was the meeting with their Ad Hoc Committee which was studying the problems relating to state medical associations and Blue Shield plans. This was precipitated by a previous action of the National Blue Shield Board of Directors which in 1968 had passed a change in their bylaws stating that future Blue Shield plans did not have to have medical society approval. Your delegate and alternate delegate presented testimony to the Chairman of this committee relating to the past and present relationships of HMA to HMSA. It is understood at the present writing that the National Blue Shield Board of Directors has rescinded this action. What effect this will have on local Blue Shield operations is uncertain.

Since this will be my last year as your delegate, I would like to take his opportunity to express my gratitude to the Executive Secretary and Dr. George Mills, your alternate delegate, for their valuable assistance and cooperation during this period. Their presence at the annual meetings has been of considerable help since it allowed a greater coverage of the numerous meetings in progress at the same time.

Since I have served ten years as your alternate delegate and delegate, I am hereby offering my resignation to the officers and House of Delegates. Although my term continues through 1969, I believe it would be helpful to have the new Delegate and Alternate Delegate begin their service this year.

Therefore, I recommend that the Delegate and Alternate Delegate elected at this session of the House of Delegates begin their terms of office in 1969 rather than in 1970.

RICHARD D. MOORE, M.D.

AMA Delegate

Your Committee next considered the report of the AMA Delegate. It noted the long, arduous, and dedicated service that has been given by Dr. Richard D. Moore as

AMA Delegate and expressed its sincere appreciation for the work he has done.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

MABEL SMYTH BOARD OF MANAGEMENT

The Board of Management for 1969 has the following make-up: Representing the Hawaii Medical Association are Drs. John J. Lowrey, secretary; V. C. Waite; and Carl Lum, alternate. Representing the Hawaii Nurses' Association are Gladys Tam Leon, R.N., chairman; Lucille Love, R.N.; and Roseann Poyzer, alternate. Representing the Queen's Medical Center, Mr. Alex Smith.

Building Expenses: Expenditures were normal in 1968. The building is now contemplating putting in air conditioning for the first floor. This, with the necessary remodeling, will cost around \$20,000.

Retirement Plan: The original proposal did not meet with IRS approval. A revised plan including the director has been adopted. Hawaiian Trust Co., Ltd., is the agent.

Finances: The financial position is sound. There are no outstanding bills.

The Auditor's Report has been delayed. It will be on file as soon as it is available.

Nurses & Physicians Exchange and Radio Page Activity Report

The average number of calls per month during the year was 21,995. Membership remains about the same.

	1968	1969
Physicians	275	279
R.N.'s	99	94
P.N.'s	26	25
Radio Page	116	116
Plus two clinic groups		

JOHN J. LOWREY, M.D.

Board of Management

Your Committee next considered the report of the Board of Management of the Mabel Smyth Building. Your Committee recommends approval of this report.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

TREASURER'S REPORT

The breakdown of income and expense at the end of this report contains three columns: (1) Proposed budget for 1969-70, as approved by the Council. (2) Actual income and expenses for the first nine months of the current fiscal year. (3) The amounts approved for the 1968-69 fiscal year.

1968-69 Income: Despite the anticipated reduction in the 1968-69 income, it appears that instead of the budgeted deficit of \$4,290.00, there may be an excess of income over expenses of a little over a thousand dollars. The main reason for this is that the expenses for attending AMA's New York meeting will take place in the next fiscal year. The reduction in income is due principally to the increased costs of printing the JOURNAL. Nevertheless the JOURNAL continues to carry itself. The only thing the Treasurer can anticipate at this time which might upset the estimated income account is if we fail to collect the dues of members who are delinquent at the time this report is being prepared.

1968-69 Expenses: Committee expenses will probably run about \$7,000.00 less than budgeted. Accounts which will be in excess of the amounts budgeted include insurance, due to increase in cost of health insurance premiums; postage, due principally to increased mailings; rent, due to a mid-year increase in the rate being charged;

retirement, due to the results of the three-year actuarial review; salaries due to including allotments under committee expense in the general salary accounts; stationery and printing, due to increased mailings and use of the Xerox to reduce staff time; telephone and cable, due to increased communications with the neighbor islands. The accounts where the amounts spent will be less than budgeted are for: legal counsel, because extended negotiations were not carried out with either HMSA or Workmen's Compensation; mainland travel, because the AMA meeting will take place in July this year.

1969-70 Income: This account as presented will be lower due to increased expenses in publishing the JOURNAL and the Roster. As in the last budget, fixed expenses such as rent, salaries, taxes, etc., appearing in the operating budget are prorated to three accounts—JOURNAL, Roster, and Annual Meeting. These are shown as reimbursement figures at the bottom of the columns and lower the total estimated expense figure, \$12,420.00. There is a corresponding decrease in the three income accounts to which these amounts are charged.

1969-70 Expenses: The budget was discussed at the April 23 and May 15 meetings of the Council. The approved budget shows an estimated deficit of \$29,750.00. The increases are mainly in the following categories: the usual increase in salaries, mainland travel, meeting expenses, the newly created Public Affairs Department, stationery, and the Woman's Auxiliary allocation.

Inasmuch as three AMA conventions will be held during our next fiscal year, the expenses for mainland travel will be unusually high. Means of cutting these costs down were discussed. The final compromise was that since Dr. Moore does not plan to attend the July meeting in New York, the expenses of only four need to be budgeted. For the clinical session only two are budgeted. The per diem was cut from \$50 to \$35 for four days at the clinical session and five days at the annual session. First-class air fare is provided for all participants. The original proposal contained funds for three trips to Chicago in order that the HMA could send representatives to important AMA meetings the scheduling of which is not known when the budget is prepared. This \$1,500 has been eliminated in the final version. Eliminated in both versions was the \$1,800 for special authorized expenses. The Council per diem and meal expenses were eliminated. One item which has not been budgeted is the fee for the management consultant to be engaged by reason of action by the Council.

General and Special Funds: For the fiscal year ending June 30, 1968, the general fund was \$95,661.29 including \$93,042.13 in the various savings and loan accounts. The same figures for June 30, 1967, were \$83,602.05 and \$78,218.37. The general fund figures which are listed exclude the depreciation which was taken for the first time during the last fiscal year. As of March 31, 1969, the unaudited figures were \$102,699.46 and \$66,819.94, again excluding depreciation. The \$102,699.46 figure includes \$27,431.44 in the checking account. A large portion of this amount was transferred to savings and loan accounts early in April.

As of March 31, 1969, the Physicians' Benevolent fund had accumulated \$31,501.62, compared to \$29,945.06 at the same time last year. The total value of the Employees' Retirement Funds as of March 31, 1969, was \$16,542.46, compared to \$14,504.75 for the same date in 1968. The 1969 figures does not reflect the 1969 HMA contribution.

RECOMMENDATIONS: (1) That the following budget for 1969-70, which has been approved by the Council and which deserves your close scrutiny, be adopted subject to inclusion of a management consultant's fee and the revision of committee expenses as approved by the House of Delegates. (2) That the dues for the calendar year 1970 remain at \$140 for active and \$47 for inactive members. (3) That Leong and Leong, our present auditors who have served us well, be retained.

HERBERT Y. H. CHINN, M.D.

BUDGET AS APPROVED BY
HOUSE OF DELEGATES

NAME OF ACCOUNT	INCOME		
	ACCUMU- LATED 9 MOS. 1968-69	BUDGETED 1968-69	PRO- POSED 1969-70
Membership Dues	\$ 63,644.00	\$ 97,330	\$ 98,520
JOURNAL	(2,927.66)	(3,530)	(8,130)
Annual Meeting	4 623.12	(300)	(30)
Annual Roster	(698.78)	(50)	(1,350)
Interest Income	1,777.81	3,400	3,400
Miscellaneous Income	564.10	1,200	1,000
Miscellaneous Scientific Activities			
Gain or Loss on Various Activities			
What Goes On	700.00	1,000	
TOTAL INCOME	\$ 67,682.59	\$ 99,050	\$ 93,410

EXPENSES			
Audit & Accounting			
Audit	\$ 485.00	\$ 450	\$ 500
Accounting	1,500.00	2,100	2,300
Auto Expense	903.75	1,200	1,200
Council Expenses			
Travel	284.24	840	780
Meals	308.10	400	200 ¹
Per Diem	66.89	780	
Donations	20.00	20	20
HAMPAC		500	200
Insurance	1,181.94	850	1,600
Library Contribution		100	100
Legal Counsel		3,200	1,500 ²
Meeting Expenses	2,638.75	3,200	4,000
Miscellaneous	84.85	300	300
Postage			
Stamps	106.93	200	200
Bulk Mailing	560.95	700	800
Permit	30.00	30	30
Meter Rental & Postage	1,222.68	1,200	1,500
President's Contingency Fund	52.14	500	1,000 ³
Rent	3,628.58	4,490	4,950
Repairs & Maintenance	217.41	250	300
Retirement	210.00	4,000	5,330
Salaries	33,356.40	42,230	46,500
Stationery, Printing & Supplies	2,007.88	1,400	3,000
Subscription & Dues	867.81	870	950
Special Authorized Expenses	600.00	1,800	
Public Affairs			
Management Consultant			2,500 ⁵
Taxes			
Social Security Taxes	1,269.41	1,850	2,200
Unemployment Compensation	225.60	500	300
Other Taxes	79.34	100	100
Telephone & Cable	1,687.79	2,000	2,000 ⁴
Travel			
Inter-Island	732.99	1,400	700
Mainland	1,692.10	8,200	7,000 ⁷
Woman's Auxiliary	2,288.75	3,480	4,200
Furniture & Fixtures		600	600
SUBTOTAL	\$ 58,310.28	\$ 89,740	\$ 96 860*
Committee Expenses	9,191.32	25,020	21,975*
TOTAL	\$ 67,501.60	\$115,760	\$118 835*
Less JOURNAL Reimbursement	(6,300.00)	(8,400)	(8,400)
Less Roster Reimbursement	(1,188.00)	(1,550)	(1,550)
Less Annual Meeting Reimbursement	(2,070.00)	(2,470)	(2,470)
TOTAL EXPENSES	\$ 57,943.60	\$103,340	\$106,415*
EXCESS OF INCOME OVER EXPENSES	\$ 9,738.00	(4,290)	(13,005)*

¹ Added by House of Delegates.
² Reduced from \$3,200 by House of Delegates.
³ Increased from \$500 by House of Delegates.
⁴ Deleted by House of Delegates.
⁵ Added by House of Delegates.
⁶ Reduced from \$2,500 by House of Delegates.
⁷ Reduced from \$8,030 by House of Delegates.
* Reflects changes mandated by House of Delegates.

Treasurer's Report

Your Committee next considered the Treasurer's Report. A full discussion of the budget and a review of the individual items took place. With reference to the budget, the committee recommends that certain reductions be made to reduce the deficit. It does, however, feel that the budget should include an allocation for meals for the Council. It does not feel that first-class travel should be

authorized for either the officers or the staff. These and other revisions are outlined in the recommendations listed below:

Council Expenses: Add \$200 for meals
Legal Counsel: Reduce budget total to \$1,500
Telephone and Cable: Reduce to \$2,000
Special Authorized Expenses (Public Affairs): Delete \$10,000
Travel (mainland): Reduce to \$7,000

Although the budget figures presented to this Committee did not detail the committee project expenses, your Committee feels that the budget for the Message of the Month should be deleted and that when this committee report is presented to the House for action that the House act accordingly.

Your Committee recommends approval of the budget as revised by this Reference Committee. Your Committee recommends approval of recommendations Nos. 2 and 3.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections.
It was moved and seconded that the portion of the Reference Committee's report which refers to the Message of the Month be deleted as this item is discussed under the committee report. The motion passed.

It was moved and seconded to increase the President's Contingency fund from \$500 to \$1,000. The motion passed.
The report was adopted as amended.

FINANCE

At the three meetings held, the committee discussed the areas assigned to it by the House of Delegates; namely, the development of a master plan for a sound financial program for the Association, and disposition of the Physicians' Benevolent Fund.

The development of an over-all investment program for the Association has been handicapped by not being able to act on the \$30,000 commitment the Association made to the Medical Plaza. The outcome of negotiations with the various government agencies involved in this project is still not known. At this point the outlook for obtaining land for the Medical Plaza is not promising. The committee has outlined a study program for itself in the areas of (1) short-term, fluid investments; (2) long-term investments; (3) the Physicians' Benevolent Fund; (4) promotion of the Annual Meeting as a source of income; (5) initiation of dialogue with other concerned parties relative to developing the Mabel Smyth Building to provide more space of the HMA, HNA, and HCMS activities.

The committee polled the membership relative to the disposition of the Physicians' Benevolent Fund and the results were as follows: In answer to the question "Do you think there is a need for a PBF?" 98 replied yes; 224, no; 19 were in doubt; and 5 did not answer. In answer to the question "Would you be willing to make contributions until \$150,000 is attained?" 86 replied yes; 202, no; 7 were in doubt; and 51 did not answer. Suggestions were requested. The proposal that the money be transferred to the general fund of the HMA was made by 75, many of whom wanted it invested to defray a dues increase. Twenty-five wanted the fund used to offset dues; seven suggested that it be used for a building fund; and 25 wanted it used for educational purposes. Twenty-seven wanted the money returned. This last suggestion presents many problems.

Last November the Internal Revenue Service audited the Association's books and the agent cautioned that should the Association commence to make distribution out of the PBF to any member for benevolent reasons, this might cause the Association to disqualify itself as a tax-exempt Association under section 501 (c) (6). He suggested that the Association file for exemption under section 501 (c) (3) as soon as practicable. This advice

resulted from the agent's interpretation of IRS procedure #63-30. Our auditors interpret this as merely a modification of IRS procedure which permits an organization to file for an exemption before it has actively operated the fund. The earlier ruling did not permit us to file under section 501 (c) (3) until such time as the Association had actively operated the fund for at least 12 months.

The auditors recommended that the HMA consider one of the following four steps: (1) Reaffirm the original objectives of the PBF and file now for exemption. (2) Reaffirm the objectives of the PBF but wait until 12 months after the actual disbursements of such benevolent funds. (3) Close out the existing PBF account by merging it into the general fund. (4) Close out the existing PBF account and reimburse the members.

The committee voted to recommend that the PBF be used as an investment fund, the income of which to be used to reduce operating expenses of the HMA. Subsequent to the April 15 meeting when this action took place, the chairman has been advised of several instances where members are or may be in serious financial straights.

Last year the committee met with Mr. Getschmann of Hawaiian Trust to review the portfolio of the HMA pension plan, which is invested in a contract equity fund and a fixed income fund. The contract equity fund increased 16% over the previous year. At that time the HMA had 59% of its portfolio in the equity fund, which will be increased to 70% in order to provide a greater return. The committee also met with a representative of the actuarial firm and was advised that an audit was in order. As a result of this actuarial reappraisal, the HMA's contribution had to be substantially increased. The actuary also submitted some proposed revisions. These were studied and an intermediate proposal accepted. However, there has been no follow through inasmuch as the Council felt that action should be deferred pending finalization of the Honolulu County Medical Society's proposed revision of its pension plan. In connection with the study of the pension plan, the committee also reviewed the salary and job description of each of the Association's employees. The job descriptions were developed for the subcommittee of the Bureau of Research and Planning which is charged with reviewing the organizational structure of the Association.

RECOMMENDATIONS: (1) That the committee continue to study avenues which will provide greater returns on its investment. (2) That if the Medical Plaza project is abandoned, the funds committed become part of the over-all investment funds. (3) That definitive action be taken by the House of Delegates relative to the Physicians' Benevolent Fund. (4) That when the HCMS pension fund plans are finalized, a comparison be made with the HMA's pension fund provisions.

HERBERT Y. H. CHINN, M.D.

Finance Committee

Your Committee next considered the report of the Finance Committee. Your Committee recommends acceptance of recommendations Nos. 1, 2, and 4. With reference to recommendation No. 3, your Committee feels that a committee should be set up to investigate ways of increasing the PBF fund and the uses to which it might ultimately be used and that the existence of such a fund be publicized to the membership. Your Committee recommends approval of this report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections.

It was moved and seconded to amend recommendation No. 3 by substitution of the following: "That the PBF be retained with its original objectives and that the House file for a C-3 status under the IRS. That a subcommittee of the Finance Committee be appointed to manage this fund and embark on an aggressive investment

program and to seek and encourage donations to this fund. That the Finance Committee report to the House of Delegates with recommendations as to the amount that needs to be attained before disbursement can be made from the fund. That the fund receive monies to disburse to designated needy members or their families.

There was a tie vote and the motion was declared defeated.

This portion of the report was adopted as recommended by the Chairman.

PRESIDENT'S REPORT

I would like to take this opportunity to express to every member of the Hawaii Medical Association my appreciation for the great honor of serving as your president. And I especially want to thank the other officers for their assistance which has been so helpful. Without them, it would have been extremely difficult to carry out the duties of my office.

The many trips I have made to Honolulu to attend meetings have been very educational. Others have said it before me but I believe the wish that every physician in the Association could be president bears repeating.

The hard-working commissioners and committee chairmen have carried out their assignments with insight and devotion. I am most grateful to them for the work they have done to further the objectives of the Association. An organization such as ours is dependent upon the dedication of its volunteer workers. We all owe them a debt of gratitude.

I have no specific recommendations to make but I would hope that the Association will continue to find ways of developing more involvement of the neighbor island doctors. We are interested and want to do our share.

ROBERT M. MIYAMOTO, M.D.

President's Report

Your Committee next considered the report of the President. Your Committee recommends acceptance of this report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAMPAC

The Hawaii Medical Political Action Committee, better known as HAMPAC, has come a long way since it was first founded by the House of Delegates of the HMA.

Membership in HAMPAC is more than double what it was in 1965. AMPAC, the parent organization, boasts of being the second largest medical organization in the United States.

Because of the tremendous increase in membership, and because of the active participation by doctors and their wives, HAMPAC and AMPAC were able to support more candidates in the last election than ever before. Eighty-three per cent of the candidates supported by HAMPAC were elected. AMPAC did equally well at the Congressional level.

Since a large percentage of doctors are already members of HAMPAC and AMPAC, they are aware that these organizations are designed to provide the medical profession with a bipartisan program of political education and political action.

The continued increase in membership, together with the fact that physicians and their wives are becoming increasingly involved in political action programs, may well cause the next election to be one of the most exciting ever.

The cost? \$20.00 per physician or wife, \$30.00 for both.

The benefit? Absolutely UNLIMITED!

DON E. POULSON, M.D.

HAMPAC

Your Committee next considered the report of HAMPAC. A full and complete discussion was held. Your Committee recommends acceptance of this report.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

SECRETARY'S REPORT

The total active membership of the Association as of December 31, 1968, was 768, an increase of 7 over December 31, 1967. In 1967 the increase was 18, in 1966 it was 25, in 1965 it was 41, in 1964 it was 17, and in 1963 it was 37. The inactive members, reported only through Honolulu County, numbered 11, the same number as the previous year. Of the 768 active members, 68 were granted dues waiver, an increase of 12 over the previous calendar year.

The total number of unlimited licenses issued to physicians to practice medicine in Hawaii as of December 31, 1968, was 1,439, an increase of 63. The preceding years this increase amounted to 71 in 1967, 112 in 1966, 53 in 1965, 34 in 1964, and 62 in 1963. There were 466 physicians licensed to practice in Hawaii who did not reside in the State, an increase of 12 over the previous year.

The first temporary and limited licenses were issued July 2, 1965. These licenses are valid for 18 months only, except that interns and residents are required to renew annually. In the calendar year 1966 a total of 120 T&L licenses were issued. In 1967 the total number decreased to 117. The total for 1968 was 129 which are broken down as follows:

Under the direction of	40
Resident & Resident	75
Government	11
Emergency	3
Shortages	0

All counties now accept for membership physicians holding T&L licenses. Honolulu County has adopted new bylaws which provide that physicians not in private practice may apply for inactive membership. This has eliminated the problem previously encountered where fully licensed doctors were carried as inactive members.

Six members died during 1968: Clarence E. Fronk, Richard T. Hata, James Warner, Eldon R. Dykes, James T. Kuninobu, and John W. Devereux.

Unaffiliated physicians were reported by the counties as follows: Hawaii 7, Honolulu 192, Kauai 2, and Maui 4.

By counties, the active membership was made up as follows as of December 31, 1968:

	ACTIVE DUES PAYING	ACTIVE DUES WAIVED	TOTAL
Hawaii	46	7	53
Honolulu	603	56	659
Kauai	16	1	17
Maui	35	4	39
TOTAL	700	68	768

Since the last annual meeting there have been four Council meetings. These were held on October 23, January 22, April 23, and May 15.

At the October 23 meeting the Council voted to accept the resignation of Dr. Mamiya as Chairman of the Bureau of Research and Planning. It was voted to appoint Dr. Ralph Beddow to this position. He declined the invitation and Dr. Joseph Oren was subsequently named chairman. Dr. John R. Stephenson's resignation as chairman of the Commission on Public Health was not accepted. Dr. Theodore T. Tomita's resignation to the committees on which he had been serving was accepted. The Council strongly endorsed the St. Francis Hemodialysis Center. Endorsement was also given to Dr. Jordon

S. Popper's stroke program. Authorization was given to buy space in the publication of the Hawaii Chapter of the SAMA. It was voted to support the Biomedical Library at UCLA. A biliary atresia study was endorsed as was a follow-up study of a small group of CEP patients provided the program was completed within the following nine months. A resolution was adopted requesting that the HMA exert every effort to have passed by the Hawaii State Legislature during the 1969 Session legislation which would amend the Medical Practice Act by adding a provision that all physicians and surgeons applying for licensure to practice medicine or surgery under the provisions of Chapter 64 or Chapter 70 of the Revised Laws of Hawaii be required to pass the same examination. The Council voted to pay the full insurance coverage for employees' families when only one member of the family of two or more is a wage earner. It accepted the Treasurer's recommendation that the \$1,500 OCC transferable membership continue to be held in the suspense account. Outstanding accounts for the JOURNAL and Roster were written off. The legal counsel was asked to advise Unigraphic through their attorney that no further efforts would be made to collect the outstanding accounts for layout. The dues for inactive members were set at \$47.00 for 1969. It was voted to request RMP funds for continuing publication of *What Goes On* and if these weren't forthcoming, to request them through California. Reports of the committees and commissions were accepted and the following recommendations approved: That the HMA study the intent of PL 89-239 and determine if the RMP operation in Hawaii is in line with the intent of Congress. Dr. Winfred Lee's Commission was asked to make this study. That the HMA concur with the idea of a cooperative organization for continuing education under the leadership of HMA through RMP funding and other resources. The Council voted to leave the priorities for study mandated by the House of Delegates up to the Legislative Committee. It also voted to oppose any action relative to a cut in Title XIX matching funds. With reference to negotiations with carriers, it voted that there be re-evaluation of the mandate of using the RVS at a conversion factor rather than the usual, customary, and reasonable fee approach. The Council agreed with the Workmen's Compensation Committee that postponement was in order for legislative changes previously approved by the House of Delegates, and agreed that the matter of a public hearing should be pursued. The Department of Health's injury program was endorsed as were three proposed programs of the American Cancer Society. The Diabetes Committee was given approval in principle to draw up a program of diabetes screening in the Trust Territory. The request from the Medicine and Religion Committee for funds was denied. Approval of the use of by-lines by physicians who write newspaper articles was not given. The use of the money allocated for a luncheon for the Woman's Auxiliary was diverted. Another invitation to the AMA to hold a clinical session in Honolulu was extended. The following were elected to hold office in the Community Research Bureau for 1968-69: President, B. A. Richardson; Vice President, O. D. Pinkerton; Secretary, Sakae Uehara; and Treasurer, Herbert Y. H. Chinn. A resolution relative to the RMP was circulated. No action was taken on it. The Council voted that a meeting be scheduled and that Dr. Masato Hasegawa and his steering committee be invited to a confrontation regarding the resolution which would express the HMA's disapproval and request a complete change in the organization of the RMP.

At the January 22 meeting a letter from Dr. West relative to the National Center for Health Services was referred to the Bureau of Research and Planning to explore and prepare an answer. The staff was requested to circularize the entire membership relative to the opening at the University for a Dean of the School of Public Health. There were objections to the wording of a letter from the Cancer Society relative to promotion of check-ups but the principle was endorsed. The Arthritis Foundation workshop program was endorsed. It was voted to meet

with Mr. Albert Yuen to discuss ways and means to curb or level off the rising costs of medical care. The auditor's report was accepted and placed on file. Permission was given to the Bureau of Research and Planning to continue with the Sanazaro report and to poll the membership re their feeling about doing an office audit. The Nominating Committee's report was submitted. No action was taken on the Medical Education Committee's recommendation relative to the University's full-time faculty billing for treatment of staff patients. It was voted that the HMA sponsor the development of a statewide council as developed by the Medical Education Subcommittee on Continuing Medical Education and that this committee be authorized to proceed to contact the various groups outlined in its report. It was also voted that the Medical Education Committee begin immediately to revise the HMA's RMP grant application for continuing medical education and to vigorously pursue other methods of financing for the proposed Council and that the HMA be the grantee institution. Recommendations for holding annual meeting events were accepted, and the staff was requested to lay out plans for the next five conventions. It was voted to invite Dr. Dwight Wilbur to the annual meeting. It was voted that the Legislative Committee be authorized to interview and recommend the selection of the Legislative Counsel, and that his appointment and salary be subject to Council approval. Mr. Clesson Chikasuye was subsequently engaged. The previous action relative to osteopathy and the Medical Practice Act was reaffirmed. A bulletin proposed by DSS was noted and filed. The Commission on Medical Services, or one of its committees, was asked to negotiate a new fee schedule with DSS. It was voted to approve the make-up of a Medical Advisory Board to the Department of Transportation and that the physicians appointed serve anonymously and without pay. The Legislative Committee was asked to work with the Legislature in getting an adequate salary appropriation for the proposed school physician. Proposed changes in the laws governing reporting and treatment of leprosy were approved and the position taken that enforced institutional confinement for leprosy treatment is not justified by modern medicine. Endorsement was asked for the DOE sex education series *Time of Your Life*. The Council voted to support the development of and institution of a well-planned comprehensive student health program. This program is to include a well-developed sex education program that the HMA will volunteer to help develop and support. More specifically, in relation to the health education film, the HMA committees have not had the opportunity to adequately review the proposed films scheduled to be shown and therefore cannot pass judgment. The Council voted that the problem of nurses dispensing drugs in the hospital was one that was between the nurses and the hospitals. The Message of the Month Committee was told to go ahead and have a luncheon for the members of the Auxiliary who deliver the messages. The Commission's majority report on RMP was approved; three conclusions were approved, one was not approved. A committee was mandated which would meet with Mr. Cannon and RMP representatives to discuss reorganization with true representation in RMP and that this meeting include discussion of a full-time administrator. The Council asked that a letter be written to Dr. Stanley Olson in Washington. The Bureau was asked to study in depth PL 89-749 along the same lines which was done for PL-89-239.

At the April 23 meeting the resignation of Dr. Frank Bruce from the Finance and Communicable Disease committees was accepted and Dr. John Lowrey was elected to replace him on the former. Approval was given to pay travel expenses to and from Hilo for the Legal Counsel. It was voted to write to Mr. Albert Yuen to see if he felt the recent Health Care Cost Conference which was cosponsored by the Hawaii Medical Association answered his request. A report from Dr. Richard Moore on the special committee appointed to meet with RMP representatives was noted and it was voted that the President-elect be the HMA nominee to the RMP Executive Committee each year and that the HMA President appoint

three additional members to the RAG with the approval of the Council. A contribution of \$50 was authorized for the purchase of a gift certificate award for the medical assistants' seminar. A presentation was made by the Woman's Auxiliary depicting the work of the Auxiliary and outlining the need for an additional allocation from the HMA dues. It was voted that the HMA not increase its present contribution to the Woman's Auxiliary. The Treasurer's Report was reviewed and a special meeting scheduled to study it again after a revision was prepared. A lengthy discussion took place on the failure to implement the Maui County resolution relative to changes in the Medical Practice Act. The following recommendations were accepted: That the Council support the DOE in the total concept of initiating a comprehensive and integrated curriculum in family life and sex education from kindergarten through 12th grade such as seen in the 3M School health education study; affirm the School Health Committee's endorsement of the film series for 5th and 6th graders *Time of Your Life*; Support the local film production series for high school students *It's Your Health* as produced by HMA School Health Committee and DOE; and recommend the continuation of medical representation on the Review Board of DOE for Family Life and Sex Education programs. The OCHAMPUS supplemental agreement was placed on file pending further investigation. It was voted to pay \$48 of the \$809.57 refund requested by OCHAMPUS. The Ad Hoc Search Committee report, discussed in executive session, was approved.

At the May 15 meeting the Council approved the request of Mr. V. Thomas Rice to attend only the second day of the House of Delegates meeting. It was voted that the President-elect of the HMA be the appointee to the RMP Executive Committee each year, and that this appointment be submitted to the RMP after the annual meeting of the HMA. With regard to the appointment of three members to RMP's advisory committee, the Council voted that the report of Dr. Moore's ad hoc committee would be the tenor of the Council at this time. Dates and places for the annual meeting were set the next five years, the last four of which were tentatively accepted. Mr. Robert Chung provided the Council with information relative to a proposal for financing care for the DSS clients. The annual report of the Bylaws Committee was noted. The annual meeting registration fee was waived for the military physicians. It was voted to determine if Dr. and Mrs. Wilbur would be free for dinner while they are in town later in the month. An invitation was extended to Dr. Gerald D. Dorman to attend the 1970 annual meeting. The Secretary was instructed to send a letter to all delinquent members as soon as possible. The Medical Care Plans Committee recommended signing the OCHAMPUS supplemental agreement covering claims costs.

The Treasurer presented a revised budget which listed areas where reductions might be made. The Council voted to schedule five Council meetings to be held on Sundays. It reinstated the HAMPAC contribution but reduced the amount. It retained the President's Contingency Fund. It reinstated the meeting expense budget at a reduced figure. It voted that four members from HMA go to the AMA New York convention, two to Denver, and five to Chicago, travelling first class but with a reduction of per diem from \$50 to \$35. It voted to increase the allocation to the Woman's Auxiliary from \$5.00 to \$6.00. It was voted to budget \$10,000 for the Public Affairs Department. A final version of the budget was approved for presentation to the House of Delegates.

The Council went into executive session and as a result of its deliberations, the following actions were taken: It was voted to engage a management consultant to look over the operation of the HMA office and staff and to make recommendations regarding administrative functions and efficiency. The officers are to choose the consultant and make determination of the fee to be paid. The Public Affairs Department will not be established until after receipt of the consultant's report.

RECOMMENDATIONS: (1) That the House of Delegates set the dates and places for the next five annual meetings as follows: 1970, week of May 3-9, Hilton Hawaiian Village; 1971, week of May 16-22, Sheraton Meeting Hall; 1972, week of May 7-13, Hilton Hawaiian Village; 1973, week of May 6-12, Sheraton Meeting Hall; 1974, week of May 5-11, Hilton Hawaiian Village. (2) That the Council be granted permission to change the sites and dates of the meetings if unforeseen events develop to make the change advisable.

R. VARIAN SLOAN, M.D.

Secretary's Report

Your Committee next considered the report of the Secretary. A full and complete discussion of the report was held. Your Committee recommends acceptance of recommendations Nos. 1 (correcting the dates for 1971 to May 2-8) and under recommendation No. 2, the word "unforeseen" should be deleted. Your Committee also suggests the addition of recommendation No. 3 to read as follows: That the officers are to proceed as soon as possible, as voted by the Council, to obtain a consultant to make recommendations regarding administrative functions and efficiency and, if possible, the cost be kept under \$2,500.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC SEARCH

This committee was formed at the request of the Council as a result of the action which is reproduced below:

It was voted that the HMA President appoint an ad hoc committee, to study the problem of obtaining personnel, space, and cost for two research bureaus and visitation to doctors' offices and report back in 30 days.

The present chairman took over on November 18, 1968, following the acceptance of Dr. T. T. Tomita's resignation, and called a meeting for March 5, 1969, at which time it was recommended that a Public Affairs Department should be formed with a director to be employed at a salary of \$950 plus a \$50 monthly car allowance. In addition, the Department was to have a \$2,000 budget for expenses and to be assigned one secretary. A job description which had been developed prior to the meeting was reviewed and approved. It is attached.*

At the April 23 meeting of the Council it was voted to form this new department, and that it should carry a salary of \$830 for the director. The organizational structure was changed to place the position of director under the executive secretary, to implement the department effective May 1, and to offer the position to Mr. Patrick Godfrey.

At the May 15 meeting of the Council a budget of \$10,000 was recommended for the new department for the coming fiscal year. Since Mr. Godfrey did not accept the position, no expenditures have been made to date in the current fiscal year.

BUDGET REQUEST:

Additional salaries, expenses, etc.....\$10,000.00†

RECOMMENDATIONS: (1) That the Department of Public Affairs be implemented as soon as possible. (2) That since the purposes for which this committee was established have been achieved, it should be disbanded.‡

WILLAM E. IACONETTI, M.D.

* On file in the Association's offices.
† Deleted by the House of Delegates.
‡ Corrected by action of the House of Delegates at its opening session to read: "The purposes for which this committee were established have been achieved, but it should not be disbanded until after an evaluation of the concept is made."

Ad Hoc Search Committee

Your Committee next considered the report of the Ad Hoc Search Committee. A full and complete discussion of the report was held. Your Committee recommends that the budget request for \$10,000 be deleted. Your Committee also feels that recommendation No. 1 should read as follows: That the Department of Public Affairs be implemented as soon as economically feasible. Your Committee recommends that this committee be continued.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

It was moved that the implementation of the Public Affairs Department be at the discretion of the president. The motion was ruled out of order.

Resolution No. 2

Your Committee recommends that this resolution relative to the PBF not be adopted.

ACTION:

The Chairman recommended that the resolution not be adopted. It was voted not to adopt the resolution.

Resolution No. 3

This resolution refers to revisions in the Medical Practice Act. Your Committee recommends that the resolved portion of this resolution be amended to read: "That the Medical Practice Act Committee be instructed to immediately embark on a series of meetings with members of the State Board of Medical Examiners, the Attorney General's office, and the Osteopathic Association to revise the current Medical Practice Act to make it more flexible and less subject to change by special interest legislation.

ACTION:

The Chairman recommended that Resolution No. 3 be adopted as amended. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 3 AS ADOPTED

Re: Revisions in the Medical Practice Act

WHEREAS, In the current session of the State Legislature more than one bill has been introduced requesting exceptions in the procedure for licensing physicians in the State of Hawaii; and

WHEREAS, New procedures for examining candidates for medical licensure are being adopted in other states; and

WHEREAS, If the physicians through organized channels do not take the leadership in proposing changes in Hawaii's Medical Practice Act these changes will be formulated by nonphysicians; now therefore, be it

Resolved, That the Medical Practice Act Committee be instructed to immediately embark on a series of meetings with members of the State Board of Medical Examiners, the Attorney General's office, and the Osteopathic Association to revise the current Medical Practice Act to make it more flexible and less subject to change by special interest legislation.

Submitted by MOR J. MCCARTHY, M.D.

Resolution No. 14

This resolution relates to community health planning. Your Committee recommends that the resolved portion of the resolution be amended to read as follows: "That the House of Delegates direct an ad hoc committee be formed to establish guidelines. . . ."

ACTION:

The Chairman recommended that Resolution No. 14 be adopted as amended. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 14 AS ADOPTED

Re: Community Health Planning

WHEREAS, The Honolulu County Medical Society has seen fit to establish a Community Health Planning Committee for the purpose of working with the several communities on the Island of Oahu in the field of planning for health care personnel; and

WHEREAS, It is the hope that through this planning activity, the preservation of private practice of medicine may be enhanced and encouraged; and

WHEREAS, Cooperative efforts are required in arrangements between medicine and government to carry out the objectives of the planning activities; and

WHEREAS, From time to time the activities of government and the medical profession appear to be in conflict; and

WHEREAS, The Honolulu County Medical Society finds no firm policy statement extant emanating from the Hawaii Medical Association that will provide guidelines for the Honolulu County Medical Society or any other county society in Hawaii in their relationships with governmental delivery of health care services; therefore be it

Resolved, That the House of Delegates direct an ad hoc committee be formed to establish guidelines for the approval or disapproval of the delivery of health care services through governmental facilities and the expansion of such facilities such as the following, but not limited to the example facilities: Waimanalo Child and Youth Center, MIC program in Nanakuli, Treatment and Diagnostic Centers as proposed in the Model Cities master plan, Comprehensive Community Health Centers as proposed by OEO, and others.

Submitted by the
HONOLULU COUNTY MEDICAL SOCIETY

Resolution No. 17

This resolution relates to osteopathy and the Medical Practice Act. Your Committee recommends that this resolution be adopted.

ACTION:

The Chairman recommended that Resolution No. 17 be adopted. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 17 AS ADOPTED

Re: Osteopathy and Medical Practice Act

WHEREAS, It is the intent and purpose of the Hawaii Medical Association to safeguard the health of the people of the State of Hawaii; and

WHEREAS, Chapter 70-11 of the Revised Laws of Hawaii 1955 state "In public institutions osteopathic physicians and osteopathic physicians and surgeons licensed hereunder shall have the same privileges and the same rights to practice their profession in the treatment of cases and the same right to hold office as are accorded to physicians and surgeons of other schools"; and

WHEREAS, The requirements for licensure for Medical and Osteopathic physicians in the State of Hawaii are *not* equal with regard to (1) residence requirement, (2) reciprocity, and (3) examination; and

WHEREAS, Doctors of Medicine object to this inequity in the law; and

WHEREAS, The American Medical Association (House of Delegates, December, 1968) seeks, as one of three objectives, to provide avenues whereby qualified osteopaths may be assimilated into the mainstream of medicine; and

WHEREAS, To achieve these objectives, the American Medical Association (1) suggests that accredited hospi-

tals may accept qualified osteopaths for appointment to the medical staffs of hospitals, (2) suggests that each county and state medical society may accept qualified osteopaths as active members and thereby provide for their membership in the American Medical Association, (3) recommends that determination of qualification be made at the level of the medical staff of a hospital, the county medical society, or the Review Committee and Boards having appropriate jurisdiction, (4) suggests that American Medical Association, state and county societies; and other affected organizations may proceed to make such constitution and bylaws changes as are necessary to implement the foregoing; and

WHEREAS, Several of the many states already have single medical practice acts or composite boards of examination (20 states) to provide for uniform certification and licensure; and

WHEREAS, Efforts are being made in several states to secure enactment of a single practice act which would require that all who practice the healing art without limitation take the same examination after having demonstrated appropriate qualifications as applicants for licensure; and

WHEREAS, The objections and the objectives stated above can best be met at this time and under present conditions by a single Medical Practice Act or a Composite Board of Examiners; and

WHEREAS, The Council of the Hawaii Medical Association adopted the resolution on Medical Practice Act submitted by a component county society dated June 18, 1968; therefore, be it

Resolved, That the Hawaii Medical Association, through its appropriate Commissions and Committees, exert every effort to have passed by the Hawaii State Legislature during the 1970 Session legislation which would amend the Medical Practice Act. This legislation should provide that all physicians and surgeons, whether medical or osteopathic, applying for licensure to practice medicine or surgery under the provisions of Chapter 64 or Chapter 70 of the Revised Laws of Hawaii 1955 be required to meet uniform and equivalent standards of (1) residence, (2) reciprocity, and (3) examination, through a single Medical Practice Act or a Composite Board of Examiners.

Submitted by MAUI COUNTY MEDICAL SOCIETY

ACTION:

The Chairman moved adoption of this report as a whole as amended. It was adopted.

**INSURANCE AND MEDICAL SERVICES
REFERENCE COMMITTEE**

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately 25 physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussions of the witnesses and having given careful consideration to all the testimony presented to it, your Committee is pleased to make the following report:

CANCER

The committee approved and endorsed the following programs of the Hawaii Chapter of the American Cancer Society:

1. The doctors' use of postcards provided by the Society to be sent to patients to remind patients that cervical Pap smears are due. The name and address on the cards are to be filled in by the patients who wish to receive the reminders.
2. The homemaker program to assist cancer patients.
3. The encouragement of neighbor islands to become more active in blood procurement and replacement.

A fourth proposal of requiring a cervical Pap smear for each female admitted to the hospital resulted in the formation of a subcommittee to study and report on the

number of cervical Pap smears being done in the State of Hawaii and whether such a requirement is justified and desirable. The subcommittee chaired by Dr. Kleona Rigney reported that a minimum of 99,499 Pap smears were done in the year 1967 in the State of Hawaii from figures gathered from hospitals and private laboratories in the State. In addition, about 500 smears were interpreted in Oregon, resulting in a total of 105,499 smears. It was not determinable how many other out-of-state laboratories were also processing Pap smears from Hawaii. There was a one per cent yield for pathology. Since the number of females in the State who were 20 years or over in 1967 was 195,663, over half the female population had a Pap smear in 1967. While a 50% screening was not ideal, it was felt that with education of the public and greater diligence of the physician, this figure can be improved. With this information the Committee declined endorsement of the proposal to make cervical Pap smear a mandatory requirement for females admitted to the hospital. It was the consensus that an adequate job is being done already and prospects of improving the screening are good. The committee also felt that there is no need for expansion of State operated facilities for physical and laboratory examinations to detect uterine cervical cancer at this time.

The Cooperative Cancer Chemotherapy program proposal to the Regional Medical Program was presented to the Committee in November, 1968. There were a number of questions raised and after considerable discussion the committee endorsed the concept of the cooperative program but not the proposal as presented. Dr. John Keenan was asked to present the program after revisions. This has not been submitted to date.

In answer to an inquiry from the Service Committee of the American Cancer Society asking our opinion regarding a request for funds to pay for x-ray therapy and laboratory costs of patients in the Queen Emma Tumor Clinic, the committee felt that funds would not be warranted for private subsidy but if it were for research the committee would consider it further. No further communications, however, followed.

The Cancer Commission report is being submitted separately.

There is no budget request.

RECOMMENDATIONS: (1) The continued cooperation and close liaison of the Cancer Committee with the American Cancer Society, the Cancer Commission, the Hawaii Tumor Registry, and the Inter-Agency Council on Smoking and Health. (2) HMA should request closer liaison with RMP regarding proposals on cancer. (3) That HMA continue to urge physicians to obtain cervical Pap smears and urge the American Cancer Society to continue to educate and encourage the public to present themselves for Pap smears. (4) That HMA support physician-directed smoking withdrawal clinics if they are established by appropriate community agencies. (5) The possible collaboration of HMA with the American Cancer Society in sponsoring a cancer chemotherapy program being planned by the latter in 1970.

THOMAS K. L. LAU, M.D.

Cancer Committee

Your Committee considered the report of the Cancer Committee. A full and complete discussion of the subject was had. Your Committee recommends an amendment of recommendation No. 5 by inserting "lectureship" after "chemotherapy." Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLICATIONS

During the past year, Dr. Harry Arnold, Jr., and Lee McCaslin have done an excellent job with the JOURNAL and few problems have arisen. We have, therefore, not had an actual meeting but have conferred about these

problems by mail. The questions follow, together with the recommendations that we have made, or are making.

The Radiological Society of Hawaii wished to run a feature in the HMJ, similar to the View Box in the Illinois Medical Journal, with similar bylines for the authors. In October, 1968, the Publications Committee suggested to the Editor that this be done. It is now a regular feature.

The Doctors Business Bureau of Hawaii submitted advertising copy in September, 1968, that raised some questions. The Publications Committee thought one phrase might be misinterpreted by some, and suggested to the Editor that this phrase be deleted. It was deleted.

Advertising from Mail Order Laboratories. There is reason to believe that we will have a request from the Upjohn Co., and possibly others, for such space. Advertisements of this type have been accepted by JAMA, California Medicine, Northwest Medicine, the Arizona Medical Journal, and possibly others. We do not know what state medical journals, if any, have refused such advertising. There have been rumors that the services provided by some of these mail order laboratories have, in some circumstances, been less reliable than those provided by local pathologists. Also, it is probable that the local pathologists may introduce a motion before the HMA House of Delegates relative to this. It is said that some local physicians, mostly internists and general practitioners, would like to be informed of the availability and details of these services, as they become available. Your Publications Committee believes that a policy in regard to publication of such advertisements should be formulated at the 1969 HMA House of Delegates meeting, and so requests.

Publication of Bylines of Medical Groups, Clinics, and Hospitals with which authors are associated has been reviewed. Some authors have included such bylines with their manuscripts. Some have been published, including "Kuakini Research Institute," "University of Hawaii Medical School," etc. Others have not been published. There has been some feeling both ways on the part of various members of the HMA. Your Publications Committee recommends that appropriate guide-lines be formulated at the 1969 HMA House of Delegates meeting.

RECOMMENDATIONS: (1) That advertising from reputable laboratories be accepted in view of its acceptance by other state medical journals and possible legal complications if refused. (2) That authors of articles in the JOURNAL be identified by their affiliation whether it be hospital, University, Department of Health, foundation, or clinic. (3) That Harry L. Arnold, Jr., be retained as Editor of the JOURNAL for the coming year and again commended on the outstanding job he has done in this capacity.

FRANK MCDOWELL, M.D.

Publications

Your Committee next considered the report of the Publications Committee. A full and complete discussion of the subject was had. Your Committee recommends that recommendations Nos. 1 and 2 be deleted and a substitute recommendation be inserted as follows: "That the next Publications Committee set up guidelines regarding the use of bylines." Your Committee further recommends that the Publications Committee hold regular, scheduled meetings. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CRIPPLED CHILDREN

The committee held one meeting during the past year.

The question of superiority of care in crippled children's clinics versus care in a doctor's office was considered. In the discussion it was pointed out that the crippled children's clinics have an advantage in the availability of paramedical help such as a nutritionist, social

worker, and public health nurse. However, a disadvantage pointed out to exist in these clinics was the periodical nature of these clinics in contrast to private physician care which is available at all times. It was finally concluded that the care of the patient should not suffer whether he is cared for in a crippled children's clinic or in a physician's office as long as adequate time and care are expended by either method.

The question of fees was again raised, i.e., an hourly rate in the crippled children's clinics versus a fee per patient in these clinics. The feeling of the committee was that a fee per hour is as much fee for service as a fee per patient and it was the recommendation of the committee that a unit value be listed in the new relative value studies.

RECOMMENDATION: (1) Another meeting is being held this year to decide on a unit value of a clinic hour to recommend to the Fees Committee. If this is not resolved at the next meeting, it is recommended that efforts toward this end be continued, and that such a procedure be included in the next RVS.

FRANCES F. NAKAMURA, M.D.

Crippled Children Committee

Your Committee held a lengthy discussion on this report and it was noted that since its filing, a unit value of six per clinic hour has been recommended by the committee. Your Committee, therefore, recommends that recommendation No. 1 be deleted. It further recommends that this unit value for the clinic hour be referred to the Fee Survey Committee for thorough and careful evaluation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AD HOC COMMITTEE TO STUDY THE RMP

At the January 22 meeting of the Council "It was voted that the President of the HMA select a committee to have a meeting or meetings with Mr. Cannon and RMP representatives to discuss reorganization with true representation in RMP-Hawaii and that this meeting is to include discussion of a full-time administrator."

Two meetings were held: one with Dr. Olson of the Washington RMP office, Mr. Cannon and Mr. Davi; and other one with Mr. Cannon and Dr. Cutting.

The following report was made to the Council at its April 23 meeting: "We learned about the relationships of the grantee institution, project coordinator, and the Regional Advisory Group. Dr. Olson said that the responsibility for administration is from the grantee institution through the project coordinator. The Regional Advisory Group is responsible for determining policy.

"An understanding was reached with Dr. Cutting and Mr. Cannon that HMA could have direct representation upon request. We therefore recommend that the Council request the grantee institution to appoint three representatives of the Hawaii Medical Association to the Regional Advisory Group. There are two methods of doing this; either by appointment of the HMA physicians already serving on the Regional Advisory Group or by appointment of additional members. It is also recommended that a committee be established within the Bureau of Research and Planning and charged with the responsibility of insuring adequate communication with the designated HMA representatives to RMP."

RECOMMENDATIONS: (1) That the University of Hawaii be asked to appoint three doctors to RAG nominated by the HMA; that these be in addition to any physicians now serving in this capacity; that these appointments be made immediately; that the terms of office be the same as for other members of the RAG; that the initial appointments be staggered for continuity, for example, one for one year, one for two years, one for three years, and subsequently all appointments be for three years. (2) That this committee be disbanded and future activities relating

to the study of RMP be carried on by the Bureau of Research and Planning.

RICHARD D. MOORE, M.D.

Ad Hoc Committee to Study RMP

Your Committee had a prolonged discussion on this ad hoc committee report. It feels that the committee should continue to function until its recommendations are implemented and to continue to share communications with all concerned parties, including the Bureau of Research and Planning. We recommend approval of recommendation No. 1. We further recommend that the ad hoc committee continue to study the advisability of RMP's having a full-time Project Director.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections.

It was moved and seconded that the last sentence of the Reference Committee report be amended to read: "We further recommend that the ad hoc committee continue to study the advisability of RMP's having a full-time paid administrator." The motion was passed.

The report was adopted as amended.

FEE SURVEY

This committee has met regularly at weekly intervals. We are involved in the seemingly interminable task of doing a complete revision of the Hawaii RVS at the direction of the House of Delegates. The importance of the committee's task is constantly foremost in the minds of the hard-working committee members since the results of our deliberations affect the practice and pocketbook of every practicing physician in the State. The endless details involved, therefore, take on greater significance. The chief reasons for the revision are: (1) To correct obvious typographical and other errors found in the first edition. (2) To add new procedures and assign values thereto. (3) To delete obsolete and obsolescent procedures. (4) To reevaluate all procedures in the light of present practice.

Surprisingly few changes in relativity have appeared, although a few have been found. The services of dozens of doctors not on the committee have been used in consultation, and the committee wishes to extend its gratitude to these physicians for their contributions.

Unfortunately the tremendous amount of detail work involved has prolonged the analysis, and it appears that the new revision is still several months away. Delays in publication may be extended further if the national trend of coding procedures in five digits, rather than the four presently used, is adopted.

Since the survey becomes vital in the work of other related committees such as Negotiating, Workmen's Compensation, etc., our job demands that we keep abreast of changing dollar values assigned to the various procedures as well as the relativity set forth in units. Accordingly, a second survey designed to update the dollar values was conducted in the early spring. This work was charged against the printing account.

BUDGET REQUEST:

Statistical Services	\$ 600.00
Preparation for Printing.....	500.00
Printing of the RVS.....	2,000.00
Issuance of Addenda.....	500.00

TOTAL..... \$3,600.00

RECOMMENDATIONS: (1) The policy of doing a complete revision of the RVS every three years be abandoned for the following reasons: (a) The details involved in such a revision demand literally thousands of man-hours on the part of the physicians involved. (b) The revision takes approximately two years to accomplish with weekly meetings and much "homework." (c) The results of such a study do not justify the expense and labor involved

since changes in relativity are seldom seen. (d) More significant results can be obtained by selective spot surveys which, combined with statistical data obtained from computers used by various insurance companies, allow for more expeditious incorporation of new procedures and other indicated charges, and the cost in dollars and man-hours of such checks would be much less. (e) Addenda, errata, etc., can be limited to the areas involved, and circulated as needed. The new format using loose-leaf sheets could expedite this phase. (2) The RVS be published in loose-leaf book form. (3) That addenda and errata be issued as needed free of charge to HMA members and at a cost of \$5.00 for non-HMA members who wish to subscribe, except government agencies be supplied with these sheets without charge. (4) That the charge for supplying copies of the RVS to non-HMA members be increased from \$5.00 to \$10.00, except that government agencies be supplied with these books without charge. (5) That the charge for HMA members desiring duplicate copies be set at \$5.00. (6) That the Council be given the authority to have the committee's findings printed as the Hawaii Relative Value Studies, Second Edition. (7) That the charges for clerical services be included in the regular salary budget of the HMA. (8) That the budget set forth above be approved for 1969-70.

FREDERICK B. WARSHAUER, M.D.

Fee Survey Committee

Your Committee discussed this report. It concurs with recommendation No. 1 and feels that continuing review should be carried on as necessary. Your Committee recommends approval of recommendation No. 2 with the word "may" inserted after "RVS." With reference to recommendation No. 3, your Committee recommends the following be deleted "except that government agencies be supplied with these sheets without charge." And that the similar reference in recommendation No. 4 also be deleted. Your Committee further recommends that recommendations 5, 6, 7, and 8 be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

INDIGENT MEDICAL CARE

This committee has had two meetings this year in addition to the meetings with the members of the Commission on Medical Services.

A joint meeting with the Medical Education and Hospital Committees was held on December 16, 1968, to discuss DSS matters relating to the changeover to free choice of physician and facility which will take place for urban Honolulu clients of DSS effective July 1, 1969. The four areas discussed with DSS and on which the committee developed positions and recommendations are:

(1) The effect of free choice of physician on medical education programs in teaching hospitals mainly centered about the physicians' participating in these services whether for education training programs or not. It was agreed that they should be the sole arbiters of the disposition of their fees without mandate or coercion by the institution.

(2) Concerning the fee schedule subsequent to July it was agreed that the usual and customary fee should prevail in office practice and that substandard fees should not be charged for physicians' services in a teaching hospital.

(3) It was felt the impact of the 70,000 office visits on the practice of Honolulu physicians could best be handled public relationwise by a bulletin to the HMA membership prior to July recommending how to serve these patients and handle referrals.

(4) The DSS payment for outpatient visits should be guided by our previous position that substandard fees should not be charged for physician services in a teaching hospital.

The committee met on April 14, 1969, at which time there was a discussion of DSS intent of using an outside

agent for administrative work, namely HMSA which had submitted the lowest bid. Members of the committee felt that HMSA claims review and issuing of payments on their vouchers was objectionable mainly because of prejudicial profile development. Since the matter concerning the conversion factor to be used had not been settled, it was felt that this subject should also be discussed with DSS and HMSA as to their intention.

Dr. Sia reported on recent developments in OEO project Headstart, namely in the transfer of fiscal matters from the Department of Health to Kapiolani Children's Hospital, which has brought the private physicians in to control the project. It is believed that this year it will be phased out and perhaps included under HEW instead of OEO. In any event, it was recommended that an attempt be made to continue private-sector control of all medical programs.

A short discussion of the DSS budget for indigent medical care as submitted to the Legislature was mostly based on rumor that it was in the neighborhood of \$500-800,000, which the members thought would be grossly inadequate for the expanded program and should probably be at least \$1 million.

A discussion of an in-depth study of indigent medical care was felt to be necessary as the existing definition as stated in the Bylaws was believed to be comprehensive enough. However the majority felt that the name "Indigent" should be changed to Governmental Medical Program Committee as this would eliminate the onus of the word "indigent."

There is no budget request.

RECOMMENDATIONS: (1) That the HMA change guideline #6 (page 607 July-Aug. 1967, issue of the JOURNAL) of the Ad Hoc Committee on Medical Education to read "that physicians participating in these services whether for education training programs or not, shall be the sole arbiters of the disposition of their fees without mandate or coercion by an institution." (2) That HMA should stand firm on guideline #3 of the Ad Hoc Committee on Medical Education where it states "substandard fees should not be charged for physicians' services in a teaching hospital." (3) That the HMA circulate a bulletin recommending how physicians should serve and refer the 70,000 new office visits after July 1, 1969. (4) That HMA support the control of governmental medical programs by the private sector of medicine if, and when, at all possible. (5) That the HMA go on record as supporting a realistic DSS budget for the forthcoming fiscal year.

CLIFFORD T. DRUECKER, M.D.

Indigent Medical Care Committee

Your Committee made a thorough review of this report. We recommend approval of recommendations Nos. 1, 2, 3, and 5. We further recommend that in recommendation No. 4 the word "direction" be substituted for the word "control."

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PHARMACY

The committee met on only two or three occasions during the year, largely to discuss drug problems with the representatives of the Department of Social Services. Mr. Robert Millar of DSS reported that the physicians had been very cooperative in helping to keep costs down. It seems apparent at this time that the idea of a formulary is dormant, but that if drug costs of DSS clients get out of hand, there may be renewed efforts on the part of the State to present a formulary and enforce adherence to it.

One case of sale of "sample" drugs was reported by the DSS representative. It was solved without legal steps being necessary, but a word of caution that dispensing of "samples" and charging for them is not only unethical but is illegal.

Your committee again requests that you check periodically to see that pharmacists are *labelling* drugs and also that "Take as directed" signs be discontinued.

There is no budget request.

JOHN F. CHALMERS, M.D.

Pharmacy Committee

Your Committee studied this report and recommends its approval.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HOSPITAL

There have been several meetings of various committees of Hawaii Medical Association discussing the matter of expansion of the Title XIX program to provide free choice of physician and facility. The general consensus seems to be that there should be a coordinated understanding between the Hawaii Medical Association and the Hospital Association in approaching this matter. At the present time, the Hawaii Medical Association's basic principle is that it continue, as in the past, to urge the fee-for-service concept and that hospitals do not become involved in the practice of medicine.

The rising cost of hospital care was discussed in a meeting with the Hospital Association of Hawaii. Mr. Burkett of HHA stated that the administrators of the hospitals have met with Hawaii Medical Association's Commission on Medical Services, and are trying to coordinate efforts in having a closer working relationship with the idea of identifying areas of rising costs in hospital care.

Concerning extended care facilities, there was a discussion regarding the transfer form and how it may be improved. As it now stands, the physician must fill out the form completely and sign the form, otherwise the extended care facility will not accept the patient. Mr. Burkett said that the HHA is meeting to review these forms again.

The question of physician involvement with hospital boards was discussed. It was the feeling that it may be wise that physicians actively participate and become more involved with hospital boards than they have in the past. The American Hospital Association evidently has gone on record supporting physician involvement.

I wish to thank the members of this committee for their efforts on behalf of the Hawaii Medical Association.

There is no budget request.

RECOMMENDATION: (1) That the Hawaii Medical Association take a stand to encourage further physician involvement with hospital boards.

B. ALLEN RICHARDSON, M.D.

Hospital Committee

Your Committee concurs with the contents and recommendation of this report and recommends approval.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICAL EDUCATION

The committee, in order to attack simultaneously the many problems involved in medical education in Hawaii, has divided itself into three subcommittees: (1) undergraduate education, (2) graduate education, and (3) postgraduate education. The following report will therefore consist of reports from each subcommittee.

Subcommittee on Undergraduate Education: This subcommittee involved itself mainly with the problems of the U. of H. School of Medicine and its students. It met with the faculty members from the University on several occasions and established a good liaison with them. In addition,

the chairman of the Medical Education Committee has been invited to sit ex officio on the executive committee of the School of Medicine.

The committee has met with the faculty and developed good liaison. It has thus gained insight into the problems of the School of Medicine, and in the interest of lending support to the School, which has progressed impressively in the past year, is submitting two resolutions.

Subcommittee on Graduate Medical Education: This subcommittee has concerned itself with residency and internship training programs. It has met with representatives to gather information regarding the problems that exist and also to explore the means by which the Hawaii Medical Association might help in solving these problems.

The meetings were most gratifying in that the concept of HMA interest in areas that have traditionally been the sole concern of the hospital was accepted and encouraged. The responsibility of the HMA in maintaining excellence in patient care cannot be challenged. That the HMA likewise has a legitimate interest in postgraduate medical education seems obvious. Interns and residents in their programs function as physicians and are involved in patient care. Moreover these physicians, in many instances, become practitioners in Hawaii. Therefore, it is the feeling of this subcommittee that the Hawaii Medical Association must do everything in its power to help and abet existing programs and encourage them to improve.

The difficulties in medical education are derived from several causes: (1) The disappearance of "staff patients" making the availability of private patients for teaching purposes mandatory. (2) The lack of full-time staff. (3) Inability to draw higher calibre interns and residents. (4) Duplication of efforts resulting in dispersion of available resources.

This subcommittee feels that cooperation between the hospitals must occur if these obstacles are to be overcome. The committee also feels that involvement of the University of Hawaii in these programs is essential. This subcommittee also feels that these facts are presently well known to all the involved parties and that it is merely the lack of a vehicle whereby this cooperation might occur that hinders its fruition.

The subcommittee recommends, therefore, that the Medical Education Committee's subcommittee on postgraduate education continue its present efforts to catalyze and mediate the formation of cooperative training programs involving the hospitals and the University of Hawaii School of Medicine.

Subcommittee on Postgraduate Medical Education: This subcommittee was given the task of rewriting and expanding the HMA grant application to the Regional Medical Program for the purpose of encouraging improved continuing health education facilities in Hawaii. After many meetings with various individuals in all areas of health professions, the subcommittee enlarged its concept of continuing health education to include all the health professions and asked individuals in each of the important areas to join it in forming a Continuing Health Education Council (CHEC).

Such a council met for the first time in April, 1969, and at that meeting the members selected representatives to form an executive committee, two members of which are members of the Medical Education Committee. This executive committee was charged with the responsibility of (1) developing bylaws for the proposed Continuing Health Education Council, (2) pursuing the means by which financial assistance might be obtained, (3) obtaining consultative services in order that specific programs might be established.

There is no budget request.

RECOMMENDATIONS: (1) That the Medical Education Committee's subcommittee on postgraduate education continue its present efforts to catalyze and mediate the formation of cooperative training programs involving the hospitals and the University of Hawaii School of Medicine. (2) That the next Medical Education Committee continue its close liaison with the Continuing Health Education Council and lend it its strong support.

MAX G. BOTTICELLI, M.D.

Medical Education Committee

Your Committee commends this committee for the initiative it has displayed in its pursuit of a solution for a difficult problem. It should be noted that the committee has been subdivided for the first time. It should be further noted that there was a typographical error in recommendation No. 1; to wit, the word "postgraduate" should have read "graduate." Your Committee recommends that recommendation No. 1 be approved. It also recommends approval of recommendation No. 2 revised as follows: "That the next Medical Education Committee continue its close liaison with the CHEC and continue its strong support and direction." Your Committee further recommends that representatives from each county society be invited to participate in the outer council of CHEC.

ACTION:

It was pointed out that the word "post-graduate" was not a typographical error in recommendation No. 1, and should read as originally written.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

MEDICAL CARE PLANS

The committee has had only two meetings this year—January 9, and March 20, 1969. The work of the committee was slow in getting started because of Dr. Tomita's illness and the change of chairman in midstream.

In 1967 a subcommittee of Drs. Mills, Iaconetti, and Miyashiro studied plantation medicine, and a report was submitted by Dr. Mills. The subcommittee was available for follow-up meetings with management but efforts to set up such meetings were not fruitful. The Social Security Administration has approved the AMFAC, C. Brewer, Alexander & Baldwin, Castle & Cooke, Waimea Dispensary, and Hamakua Infirmary plans as Group Prepayment Practice Plans. Under this arrangement, reimbursement is made on the costs the plan incurs in providing medical care to its members including the physician's salary/compensation.

Several discussions were had with other committees including the Indigent Medical Care Committee relative to DSS plans for July 1, 1969, when free choice of physicians under Title XIX for urban Oahu goes into effect. No action was necessary from this committee in regard to this.

Discussion was held relative to the Department of Health Specialty Clinics. The committee did agree that any physician working with multiple consultants, either physicians or paramedical personnel, can give better service to the patient but that the cost will be greater and manpower sources make it impossible for every patient to be seen in this type of setting.

The Council mandated that negotiations with carriers be reevaluated in the context of using usual, customary and reasonable fees rather than the RVS at a conversion factor. A great deal of discussion was carried out on this point and the advantages and disadvantages of the two types of fees are listed below:

Relative Merits of Fixed Fee Schedules Versus Usual and Customary as Basis for Negotiating Fees

FIXED FEE

1. Predictability for Insurance Carriers.
2. Predictability for patient who gets full coverage.
3. Individual physician may not agree.
4. Medical Association retains right to establish fee.
5. Easier to bargain with a carrier for a fixed fee. Simply decide on conversion factor.
6. Easier for the Review Committee on claims and for the claims clerks.
7. May be possible to regulate the conversion factor to the cost-of-living index.
8. New insurance plans do not have to accumulate a "profile" on each doctor.

9. The predictability factor with Medical Association rights outweighs the advantages of the usual-and-customary approach.

USUAL AND CUSTOMARY

1. Allows for individual variation among physicians.
2. Physicians forfeit right to establish fees as a group.
3. Unpredictable for patient.
4. Unpredictable for 3rd party.
5. Unpredictable for physician.

The committee felt that it should continue to study this problem and it was not ready to recommend change in the method of negotiating contracts.

There is no budget request.

RECOMMENDATIONS: (1) That the Committee continue to study the pros and cons of using a fixed conversion factor vs. the usual-and-customary approach for determining fee schedules and report its findings at the next meeting of the House of Delegates.

JOHN J. LOWREY, M.D.

Medical Care Plans Committee

Your Committee recommends deletion, under No. 5 of the usual-and-customary section, of that part of the sentence beginning with the fourth word and that this portion of the report not become a part of the proceedings of the House of Delegates. Your Committee recommends approval of the committee's recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

NEGOTIATING

This committee, under the Commission on Medical Services, was moderately active during the year 1968-1969.

With regard to negotiations with HMSA, nothing was done as we are awaiting word from HMSA after submitting a letter requesting that they accept the previously mentioned five points before commencing any further meetings. HMSA is reported to be conferring with the Attorney General.

Your chairman, as well as a few of the members of this committee, have met about four times with Department of Social Services' officials in an attempt to negotiate a fee schedule for Title XIX patients commencing July 1, 1969. Your Committee was mandated by the Council to negotiate. We asked for a conversion factor of 6.0 applied to the HRVS. We have made this known to DSS and their reply indicated that in order to get this, the HMA would have to exert pressure on the Legislature.

A meeting with the local Veteran's Administration has been scheduled and we will request that a conversion factor of 6.0 applied to the HRVS also be used as the fee schedule in the care of VA patients.

RECOMMENDATIONS: (1) That this committee continue in negotiating fee schedules for the State Association. (2) That the House of Delegates give serious consideration to the concept that, insofar as possible, fee schedules be determined on the county level.

CHEW MUNG LUM, M.D.

Negotiating Committee

Your Committee commends this committee for the work it has done and sympathizes with its frustrations. Your Committee recommends that recommendation No. 1 be approved, and that recommendation No. 2 be deleted.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ADJUDICATION

This committee has not been called upon to act during this past year and therefore has not used its budget allocation. However, in the event that problems affecting the neighbor islands should arise, it is requested that the allocation for the current fiscal year be carried over to the next period and include air fare at current rates and lodging.

BUDGET REQUEST:

Travel \$190.00*

WILLIAM W. L. DANG, M.D.

* Deleted by the House of Delegates.

Adjudication Committee

Your Committee next considered the report of the Adjudication Committee. A full and complete discussion of the subject was had. Your Committee recommends that the budget request be disallowed. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CANCER COMMISSION

The Cancer Commission met regularly each month with the exception of July and October. In addition, six special meetings of the Commission were held during the year.

RMP Grant Application: Much of the Commission's time was absorbed by problems relating to the submission to RMP-Hawaii, first in February, 1968, then again in May, 1968, of a grant proposal from the HMA for funds to expand the staff and services of the Hawaii Tumor Registry.

The first proposal (February, 1968) was never forwarded to Washington by RMP-H, for reasons unknown; the second (May, 1968), though forwarded, was sent on without the supporting documents and sample forms which had been submitted by HMA and which would be of import in national review of the application. Further, the site visit from Washington RMP members in September was of no assistance since less than thirty minutes was allotted for presentation of our proposal.

There were also difficulties caused by a lack of essential communication with RMP. For instance the fact that the grant proposal submitted in May, 1968, was deferred was known in November. After a multitude of inquiries, the Commission still has not been given a definitive set of reasons for lack of approval. This is needed in order to prepare a revision of the application. The Commission's inability to obtain this information prompted the HMA to request the services of a competent consultant, George Linden, Chief of the California Tumor Registry, to assist us in developing an approach for our next application so that it will be better received in Washington.

On the initiative of the Cancer Advisory Committee of RMP-H a meeting was held with representatives from the University of Hawaii concerning their proposal to move the Tumor Registry to the Department of Genetics at the University. This was discussed in depth. Later, at a meeting of the Cancer Commission it was unanimously agreed that because the Tumor Registry is so intimately related to patient care and is fundamentally a patient service rather than a research tool, it should be handled by the medical profession and therefore should remain under its present direction and control. The University, however, has submitted to RMP a proposal to assume the Hawaii Tumor Registry function. The status of this request in RMP is not known.

It is apparent that there is a considerable lack of knowledge about the functions, purpose, and mechanics of the Hawaii Tumor Registry in the minds of some indi-

viduals, both within and outside of the medical profession. We also realize that there is a lack of understanding which has been demonstrated through the review and evaluation process of our grant proposal. This, plus our own insight into certain deficiencies of the Registry, was also a part of our purpose in bringing George Linden to Hawaii to help clarify the situation and give us advice as to the most logical approach to increasing the service capability of the Registry as well as assisting us in our search for additional Federal funding.

Through consultation with Mr. Linden we were able to obtain greater insight into the RMP-Washington attitude toward the position of tumor registries in the cancer program. It is hoped that the application can now be finalized into acceptable form and the Registry staff at last released to do essential Registry work that has been sidetracked in the past year.

Mr. Linden has prepared an excellent preliminary report which has been received. Upon receipt of the final report it will be made available.

Other Activities: During the year, the extensive report of the Hawaii Tumor Registry, "Cancer in Hawaii—Morbidity and Treatment: Five Years 1960-1964," was published in the JOURNAL of the HMA and reprints distributed. A more detailed tabulation—by five-year age groups instead of 10-year—of the morbidity data was prepared for the Union Internationale Contre le Cancer for inclusion in their new edition of "Cancer in Five Continents." (In 1965 the Hawaii Tumor Registry contributed four-year data for publication in the first edition.)

The Registry is cooperating in two studies being conducted at the University of Hawaii: (1) study of cancer incidence in a cohort of 10,000 Japanese males being followed in a heart study, and (2) study of the possible relationship between carcinoma of the cervix and herpes virus type II. A further study will be conducted by the Registry to determine whether there is any geographic and socio-economic pattern in the incidence of cancer of the cervix. This latter study will be conducted with funds donated by the Women's Auxiliary of the Veterans of Foreign Wars. The Registry has also filled a number of minor requests for data.

RECOMMENDATIONS: (1) The Cancer Commission continues to recommend the formation of one or more advisory committees to assist the Commission. The committee or committees would be appointed by the Cancer Commission with the approval of the HMA Council.

Cancer Commission

Your Committee next considered the report of the Cancer Commission. A full, complete, and invigorating discussion was held. It was noted that the Cancer Commission was prepared to pay for the expenses of Mr. George Linden's visit, but the RMP offered and did pay for the cost of bringing Mr. Linden to Honolulu. Your Committee recommends that the word "nominated" be substituted for "appointed" in the recommendation. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

WORKMEN'S COMPENSATION

The committee has had five meetings over the past year. The recommendations submitted to and approved by the last House of Delegates have been followed. The fee schedule has been changed by the Division of Industrial Relations and Labor and was promulgated July 1, 1968. This was done without a public hearing or a determination. On January 2, 1969, a petition was submitted to Mr. Hasegawa requesting a hearing and determination. We received an answer from him asking for specific changes. Mr. Hasegawa knows that the majority of the physicians in the State use the 1965 Hawaii RVS, and

that the changes would involve the entire gamut of fees charged by physicians. There are a few specific surgical fees that have been obviously changed to less than half of the present going rate. We feel that the medical profession deserves an explanation of the reasons for making these changes.

Legislation has been submitted to require that a review and determination be made yearly. However, at the time this report is being written we do not know whether this will be enacted. Because we did not know what information Mr. Hasegawa required, Drs. Gordon and Maruyama were sent to see him to determine how to develop a questionnaire to be sent to all the doctors as a survey of the fees in this State. Mr. Hasegawa was quoted as saying that there would be a hearing in February or March of 1969. This has not yet occurred.

There is no budget request. The services of Mr. Rice, which are very necessary to this committee, are covered in the operating budget.

RECOMMENDATIONS: (1) To continue to try to get legislation which would change Workmen's Compensation laws so that they are strong enough and specific enough to require that the Director of Industrial Relations and Labor follow them. (2) The first piece of legislation recommended is to require that hearings and determinations be done on a regular basis. The law now states a "reasonable time," which in the past has been about every four years and which to the chairman is very unreasonable.

DON E. POULSON, M.D.

Workmen's Compensation

Your Committee carefully studied this report and recommends that the fifth sentence, the third and fourth words of the eighth sentence, and the entire 10th sentence be deleted and that these portions of the report not become a part of the proceedings of the House of Delegates. Your Committee further recommends that recommendation No. 1 be substituted by the following: "that the Workmen's Compensation Committee obtain legal opinion as to infractions of the law as constituted and submit specific recommendations to the HMA Council." Your Committee also recommends that recommendation No. 2 be approved.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON MEDICAL SERVICES

In addition to meeting as a Commission, the committee chairmen in this group participated in a number of joint meetings which were called for specific purposes. One of these was held to hear Dr. Robert Chung present a proposal for handling medical payments for the Department of Social Services. This proposal was subsequently presented to the Council and this Commission has been charged to study this together with other pertinent information and direct the House of Delegates of its recommendations. The proposal involves contracting with the State for a fixed sum, estimated in the neighborhood of \$15,000,000.00, to cover the entire medical costs of the DSS clients, the Commission will require some time to study the feasibility of undertaking this project and cannot at this time make any recommendation to the House of Delegates.

At a meeting called to discuss the public relations problems that may arise in connection with the DSS clients' being given free choice of physician and facility, chairmen of committees outside this commission were called in, and the following recommendations were developed:

A. Suggest to the Honolulu County Medical Society that they send out a postcard survey asking what doctors are willing to take care of DSS patients. (It was suggested to find out how many doctors are concerned and that there be a list available.)

B. That a human interest story be written up—Mr. Lytle will contact Pat Hunter and Dr. Yokoyama will contact Bill Helton.

C. That Dr. Wm. Moore be asked to speak on this subject when he addresses the Medical Assistants at their annual convention.

D. Suggest that outpatient departments at St. Francis, Queen's, Kapiolani, and Children's Hospitals canvass DSS patients to see what their intentions are when free choice becomes effective. It was suggested to work through Mr. Ollie Burkett, Executive Director of the Hawaii Hospital Association.

A letter from Attorney General's office addressed to HMSA's legal counsel, Mr. John Jubinsky, was received too late to be included in the report of the Negotiating Committee. It reads as follows:

Pursuant to your letter of March 19, 1969, this office has once again reviewed your request for an advisory opinion as to the antitrust implications of the proposed agreement between Hawaii Medical Service Association and the Hawaii Medical Association.

Analyzing the proposed agreement, in light of the Hawaii antitrust law, it is the position of this office that such agreement if entered into raises serious antitrust implications.

It should be noted that the National Association of Blue Shield Plans has again revised its bylaws with reference to medical society approval and support of Blue Shield plans. Under membership standards the NABSP bylaws reads:

A Plan shall have substantial support of the medical profession, evidence of which shall be approval of the Plan by the appropriate medical society or societies.

The AMA's Joint Conference Committee has been asked what effect this policy will have on the local situation. This will be discussed at their June 14 meeting.

Even though this report is being written at the time the Legislature is supposed to adjourn, the final DSS budget and the policies governing it are not known. The committee reports from the House and the Senate are set forth below:

SENATE

Public Welfare, Medical Assistance—In this program, your Committee is aware of the recent request made by the Hawaii Medical Association to increase payments to physicians. In this regard, it is the intent of your Committee to provide the Department of Social Services with the flexibility necessary to negotiate with Hawaii Medical Association for a satisfactory settlement. However, it is requested that a thorough review of the question be made before any decision is made.

HOUSE

Department of Social Services—Expansion has been limited to the adoption on a statewide basis the right to a free choice of physicians. This policy was mandated by the Social Security Act which made such a right a condition precedent for any State to receive federal medical assistance.

The House report also states:

The 1969 Legislature has already authorized a comprehensive medical audit of the fastest cost-rising sector, the medical assistance program. Pending the completion of this audit, your Committee has sought to maintain the current level of services.

If the House remains adamant, there is no possibility that there will be an increase in the present conversion factor. In our opinion the amount budgeted is far below what the actual costs will be even with the five conversion factor.

In discussions with the DSS, mention is frequently made that the State feels that all its divisions and departments should operate on the same fee schedule. When Workmen's Compensation is mentioned, we point out to them that this is not a State schedule, it is set by the State but the State does not pay the costs of coverage of employees of private industry.

With reference to the audit, the commission has met with Dr. Jesse B. Aronson, who is the senior consultant for Greeleigh Associates, Inc. He advised that the \$200,000 audit would not extend into doctors' offices and that it would be done by people from the Albert Einstein University. It will be similar to the one ordered by the Teamsters in New York which is usually referred to as the Trussell Report.

RECOMMENDATIONS: (1) That the commission do an in-depth study of Dr. Robert Chung's proposal and present to the Council periodic reports on the progress it is

making. (2) That the recommendations A, B, C, and D outlined in this report as a proposed program for handling the problems that may arise in connection with the DSS clients' transfer to free choice be approved and implemented. (4) That the House of Delegates adopt the position that the present policies of the HMA do not have HMA approval. (5) That the membership be notified that we could not reach an agreement on our request that the DSS establish a fee schedule using the RVS converted at six. (6) That all physicians should treat DSS patients as private patients and should bill their usual fees.

RICHARD D. MOORE, M.D.

Commission on Medical Services

Your Committee noted the many meetings of this Commission and recommends that recommendations Nos. 1, 4, 5, and 6 be approved. Your Committee further recommends that recommendation No. 2 be approved with the amendment that all counties be surveyed as suggested in recommendation No. 2(a). Your Committee also recommends that recommendation No. 3 be deleted and not become a part of the proceedings of the House of Delegates.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMUNITY RESEARCH BUREAU

The Community Research Bureau was incorporated on March 5, 1968, as a result of a recommendation developed by the Ad Hoc Search Committee. It is a non-profit 501(c)(3) corporation that provides a vehicle which can accept tax-deductible contributions from individuals, business, organizations, etc. The members of the Corporation are those persons who are members from time to time of the Council of the HMA.

The Bylaws of the CRB require its board to nominate officers for election by the Council at the Council's first meeting following the HMA's annual meeting. On October 23, 1968, the following were elected: B. Allen Richardson, President; O. D. Pinkerton, Vice President; Sakae Uehara, Secretary; and Herbert Y. H. Chinn, Treasurer. The Board of Trustees consists of the President, the President-elect, the four living immediate past presidents of the HMA, the president of each of the county medical societies, and the officers of the corporation.

The purpose of the Community Research Bureau is to receive and maintain a fund or funds of real or personal property, and to use such charitable, scientific, literary, or educational purposes. The only offer of funds to date has been from E. R. Squibb & Sons. They were given the option of contributing money to either the HMA or the CRB and elected the former. The amount contributed, \$300, is being held in a suspense account by the HMA and it is hoped further funds will be forthcoming in order that research projects of importance to the physicians can be launched. To date the only CRB financial transaction has been the payment of legal fees for incorporation.

RECOMMENDATIONS: (1) That periodic notices be placed in the Newsletter reminding the members that tax-deductible contributions can be made to the Community Research Bureau.

B. A. RICHARDSON, M.D.

Community Research Bureau

Your Committee is pleased to note the formation of this corporation and requests that it continue to report annually to the House of Delegates. It recommends approval of the recommendation.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON EDUCATION AND SCIENTIFIC RESEARCH

The major activities of this Commission have been outlined in the individual committee reports. In addition to the individual committee meetings, several joint meetings were held with other HMA committees not on this Commission. These have proved to be valuable for gaining information and direction.

A special task mandated to this Commission was the evaluation of the Regional Medical Program (RMP) in Hawaii. One of the major benefits of this study was the development of a group of physicians who became knowledgeable about the entire RMP program and its concepts. It concluded that the RMP operations in Hawaii are in accord with the mandate of Congress. Some members of the Commission felt that better means of obtaining representation by HMA on RMP was needed and that the function of RMP was to meet the needs of the community through a representative and functional Regional Advisory Group of RMP. Meetings with members of RMP-H were fruitful and all agreed that better means of communication should be developed between RMP-H and HMA and within each organization itself. This study was conducted prior to the present organizational change of RMP-H. Three of the four conclusions made to the Council by the Commission were approved. They are (1) Public Law 89-239 has been studied and the major goals of this law can be summarized to be the improvement of patient care in heart disease, cancer, stroke, and related disease by regional cooperative arrangements. (2) After studying RMP-Hawaii, no evidence was found that RMP-H's operation is being carried out contrary to the intent of Congress. (3) Better methods of communication within RMP-Hawaii, between RMP-H and HMA, and within HMA are needed.

The Medical Education Committee is to be especially commended for its diligence and achievements during the past year. One of the more important tasks that needs to be resolved will be in the formation and operation of Continuing Health Education Council (CHEC). HMA initiated the formation of this organization. It was the intent of HMA to obtain an RMP grant and other grants for continuing Medical education. The bylaws of CHEC are presently being developed by an eleven-man pro tem executive committee. Active participation by HMA in the activities of CHEC is mandatory since this is one of the main purposes of HMA as set forth in its Charter. The future course of HMA in the activities of CHEC must be clearly established at this time.

RECOMMENDATIONS: (1) That the special report to Council of the Commission regarding RMP-H and the minutes of the Commission during this study be available to all interested HMA members. (2) That the following policies be established in regards to CHEC: (a) That HMA continue its support of the evolving CHEC which it initiated. (b) That HMA take an active role in establishing an organization that will be representative of the medical and paramedical community. (c) That the HMA Council shall elect two members of HMA to be representatives on the Executive Council of CHEC in accordance to the terms established by CHEC and that these members shall be members of the HMA's Medical Education Committee. (d) That the HMA Council shall elect representatives to the Council of CHEC as needed. (e) That the elected representatives of HMA on the Executive Committee of CHEC maintain communication with HMA through quarterly reports to the Commission on Medical Education and Scientific Research and the Council; that they be responsive to the needs and wishes of HMA; that they be responsive to the needs of continuing medical education of the physicians of Hawaii; and that they be removed at any time by action of Council if the foregoing stipulations are not carried out satisfactorily. (3) That the Hospital Committee become more active and more involved, particularly in regard to the problems of Title XIX, ECF's, and the costs of hospital care. (4) That the Publications Committee be more active in the review of material published in the HMJ

before and after publication, particularly if requested by the Editor. (5) That joint meetings be held with the Hospital, Fee Survey, Medical Education, and the Indigent Medical Care Committees to resolve, rather than discuss, the future course of medical education in the hospitals which is so vital to the needs of medical education of the interns, residents, and practicing physicians.

WINFRED Y. LEE, M.D.

Commission on Education and Scientific Research

Your Committee is impressed with the fine work this commission has been doing. Your committee recommends that recommendation No. 1 be approved. Your Committee further recommends that approval of recommendation No. 2 with the addition after "2(c)" of the following: "that strong consideration should be given to having one of the two HMA members of the Executive Council of CHEC be from one of the neighboring islands." Your Committee also recommends approval of recommendations Nos. 3, 4, and 5.

ACTION:

The Chairman moved adoption of this portion of the report. There were objections. It was moved that an HMA member from one of the neighbor islands be appointed as a member of the Council of CHEC. The motion was ruled out of order.

This portion of the report was adopted as recommended.

Resolution No. 4

With reference to the resolution relative to the Medical School, your Committee had a full discussion and recommends its adoption.

ACTION:

The Chairman recommended that Resolution No. 4 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 4 AS ADOPTED

Re: Four-Year Medical School

WHEREAS, The continued existence of the two-year school of medicine has been recently questioned; and
WHEREAS, Its progress to date has been impressive; and
WHEREAS, The 1967 House of Delegates resolved to support the implementation of a four-year school as soon as it is financially feasible, now therefore, be it
Resolved, That the Hawaii Medical Association recommends the continuance of the present two-year School of Medicine and that it reaffirms its support for its enlargement into a four-year facility as soon as it is financially feasible.

Submitted by the MEDICAL EDUCATION COMMITTEE

Resolution No. 5

This resolution relates to the clinical practice of full-time University professors. Your Committee recommends the approval of this resolution with the revision of the resolved to read "That the previous resolution of the 1967 House of Delegates be amended to read: 'we affirm the right of the full-time, duly licensed faculty member, at the discretion of the University of Hawaii School of Medicine, to engage in the practice of medicine; that the faculty member should charge the customary fee; that the disposition of this fee should be at the discretion of the participating faculty member; and that the full-time faculty members be encouraged to join and become active members of their county medical society and the HMA.'"

ACTION:

The Chairman recommended that Resolution No. 5 be adopted as amended. It was voted to adopt the resolution.

RESOLUTION NO. 5 AS ADOPTED

Re: Clinical Practice by Full-Time University Professors

WHEREAS, In 1967 the House of Delegates voted that "under the present organization of the University of Hawaii School of Medicine, the HMA go on record favoring that full-time licensed faculty members be allowed, at the University of Hawaii School of Medicine's discretion, to engage in a limited physician-referral consultation practice; that the consultant should charge a reasonable fee; that the disposition of this fee should be at the discretion of the participating consultants; and that these full-time faculty members be encouraged to join the county medical society"; and

WHEREAS, In the intervening two years there have been changes made in the teaching programs and future plans of the University of Hawaii; and

WHEREAS, In view of these changes, the Hawaii Medical Association should revise its 1967 stand as it relates to the types of practice full-time University professors may engage in; and

WHEREAS, the full-time faculty members should practice medicine as demanded by their position, teaching appointments, or research, provided that they be fully qualified physicians who are licensed in the State of Hawaii; now therefore, be it

Resolved, That the previous resolution of the 1967 House of Delegates be amended to read: "We affirm the right of the full-time duly licensed faculty member, at discretion of the University of Hawaii School of Medicine, to engage in the practice of medicine; that the faculty member should charge the customary fee; that the disposition of this fee should be at the discretion of the participating faculty member; and that the full-time faculty members be encouraged to join their county medical society and the HMA."

Submitted by the MEDICAL EDUCATION COMMITTEE

Resolution No. 10

The definition of usual, customary, and reasonable is set forth in this resolution.

ACTION:

The Chairman recommended that Resolution No. 10 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 10 AS ADOPTED

Re: Definition of Usual, Customary and Reasonable

WHEREAS, There is a rapidly increasing number of programs for financing health services based upon the usual, customary and reasonable concept for payment of physicians' services; and

WHEREAS, It is in the best interest of the public and physicians of the country that a national definition of the terms usual, customary and reasonable be formulated; and

WHEREAS, The American Medical Association at its Clinical session in 1968 adopted such definitions; and

WHEREAS, It would be advantageous for the Hawaii Medical Association also to adopt such definitions; now therefore be it

Resolved, That the Hawaii Medical Association adopt the following definitions:

Usual is defined as the "usual" fee which is charged for a given service by an individual physician in his personal practice (i.e., his own usual fee);

Customary is defined as that range of usual fees charged by physicians of similar training and experience for the same service within a given specific limited geographic or socio-economic area;

Reasonable is defined as a fee which meets the above two criteria, or, in the opinion of the responsible local medical association's review committee, is justifiable in the special circumstances of the particular case in question; and be it further

Resolved, That whenever these terms are used in contracts or laws that they be specifically defined in those documents.

Submitted by RICHARD D. MOORE, M.D.

Resolution No. 11

This resolution provides flexibility in contract negotiations. Your Committee recommends that in the resolved the word "negotiable" be substituted for the word "fixed" and the word "equitable" be substituted for the word "advantageous."

ACTION:

The Chairman recommended that Resolution No. 11 be adopted as amended. It was voted to adopt the resolution as recommended.

RESOLUTION NO. 11 AS ADOPTED

Re: Contract Negotiations

WHEREAS, In 1965 the House of Delegates mandated that the "officers of the Hawaii Medical Association authorized to negotiate and sign contracts in the name of the Association be ordered not to execute any contract which binds participating physicians to a fee schedule unless that fee schedule is based on a relative value study adopted and approved by the House of Delegates of the Hawaii Medical Association"; and

WHEREAS, Since that time there appears to be a wider range in fees being charged by physicians practicing in different specialties and in different geographical locations; and

WHEREAS, It would appear to be advantageous to give the Hawaii Medical Association more freedom in negotiating contracts governing medical fees; and

WHEREAS, The usual, customary, reasonable, concept of determining fees has grown in acceptance throughout the country and is currently being used by certain insurance carriers within the state; now therefore be it

Resolved, That the 1965 action of the House of Delegates be amended so that a fee schedule can be negotiated on a usual, customary, reasonable concept or on the basis of fee schedule based on the Relative Value Studies with negotiable conversion factors, whichever appears to be the more equitable method of reimbursement.

Submitted by RICHARD D. MOORE, M.D.

Resolution No. 12

This relates to free choice for DSS clients.

ACTION:

The Chairman recommended that Resolution No. 12 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 12 AS ADOPTED

Re: Free Choice of Physician and Facility for DSS Clients

WHEREAS, This House of Delegates has already gone on record advocating the principle of free choice; and

WHEREAS, Effective July 1, 1969, by reason of Federal statute, the clients of the Department of Social Services will be given the opportunity to select their own physician or system of medical care; and

WHEREAS, The impact of this new program upon the practicing physicians cannot be accurately estimated; and

WHEREAS, Staff physicians of the various hospitals are considering the formation of several associations designed to provide the mechanism for billing for the medical care given to patients who seek physicians' services in out-patient departments; and

WHEREAS, The Hawaii Medical Association has repeatedly stressed the importance of intern and resident training programs; now therefore be it

Resolved, That every physician who is approached by

clients of the Department of Social Services do his utmost to provide them with medical care and that if this is not possible, that he direct them to other physicians where this care can be provided; and be it further

Resolved, That the associations of physicians which are formed within the various hospitals adhere to the principles adopted by this House, the guidelines set forth by the AMA, and to the principles of medical ethics; and be it further

Resolved, That the physicians of the Hawaii Medical Association continue to support to the fullest the intern and resident training programs of the hospitals of Hawaii.

Submitted by RICHARD D. MOORE, M.D.

Resolution No. 15

This resolution relates to the relationship with HMSA. A complete and full discussion was had. None of the physicians who signed this resolution appeared before the committee to testify. Your Committee feels that this resolution is redundant and recommends that it not be adopted.

ACTION:

The Chairman recommended that Resolution No. 15 not be adopted. It was voted not to adopt the resolution.

Resolution No. 16

This relates to government hospitals. There was a full discussion and divergent opinions were expressed.

ACTION:

It was moved and seconded that Resolution No. 16 be amended as follows: WHEREAS, The Joint Commission on Accreditation of Hospitals (Standard Procedures of Accreditation, December 1965), establishes the need for a governing body which must assume legal and moral responsibility for the conduct of the hospital as an institution and which must be responsible to the patient community and sponsoring organization; and

WHEREAS, To accomplish this goal the JCAH states that there must be close liaison between the governing body and the medical staff which can be accomplished only if there are good communications, effective organization, and willingness to work together (JCAH Bulletin No. 22, December 1959),

The vote to amend the resolution was defeated.

The Chairman recommended that Resolution No. 16 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 16 AS ADOPTED

Re: Hospital Governing Bodies

WHEREAS, Each hospital's Governing Body (whether also known as Board of Trustees, Managing Committee, etc.) is directly responsible for the activities of its hospital, and the Joint Commission on Accreditation of Hospitals clearly prescribes for the local and independent character of such Governing Bodies; and

WHEREAS, Act 97 of the State of Hawaii provided for the orderly transfer of various county functions to the State, including fiscal functions of certain hospitals; and

WHEREAS, It was given to understand that control, management, and operation of such hospitals would be left to the counties; and

WHEREAS, An "after the fact" interpretation of Act 97 led to provision for County Advisory Council in Act 203, with the director of the Department of Health designated as the Governing Body; and

WHEREAS, The many members of the County Advisory Councils feel impotent and confused as to their functions and responsibilities; and

WHEREAS, The Medical Staffs of these "Act 97 Hospitals" find extreme difficulty in working with a nonlocal Governing Body; and

WHEREAS, Flexibility and responsiveness to local problems and differences will be further stymied by the present situation; and

WHEREAS, Through these Acts, a conflict of interest develops in the Department of Health who acts both as a *licensing and governing* body; and

WHEREAS, The House Committee on Public Health, Youth, and General Welfare (May 6, 1969) "believes that there should be some measure of local participation in the daily operation and control of the hospitals. This can be provided for by establishing Managing Committees" composed of residents of the individual counties "which shall manage, control, and operate hospitals in conformity with the policies of the Department of Health"; therefore be it

Resolved, That the Hawaii Medical Association reaffirms the Joint Commission on Accreditation of Hospitals standards for Governing Bodies; and further be it

Resolved, That the Hawaii Medical Association, through its appropriate commissions and committees seek to have Act 97, Act 203, and other related statutes amended in the 1970 Legislative Session to restore the proper status of local governing bodies.

Submitted by Sakae Uehara, M.D.
MAUI COUNTY MEDICAL SOCIETY

ACTION:

The Chairman moved adoption of this report as a whole as amended. It was adopted.

MISCELLANEOUS BUSINESS REFERENCE COMMITTEE

Mr. President and Members of the House of Delegates:

Your Reference Committee met before an audience of approximately ten physicians and guests and received testimony on the various resolutions and reports submitted to the Committee for consideration and recommendation. Having heard the discussions of the witnesses and having given careful consideration to all the testimony presented to it, your Reference Committee is pleased to make the following report:

AMA-ERF

During the past year the local committee has continued to encourage contributions to the parent AMA committee by displays at the annual meeting and notices in the Newsletter. Also during the year the film, "A Different Drum," outlining the structure and function of AMA Educational and Research Foundation, with especial emphasis on the new research facilities in Chicago, was shown at the various local county medical society meetings.

This effort continued to be successful for last year 221 contributors gave \$6,346.12, topping the previous record year, 1967, of \$6,333.87 from 254 contributors. The Honolulu County Woman's Auxiliary was again most successful, raising \$2,245.00 by their efforts.

In return, the University of Hawaii Medical School will receive a major portion of this sum, getting a check for \$4,327.15 at the annual meeting. This compares with \$2,393.89 in 1968 and \$241.19 in 1967. It would thus appear that the members of the Hawaii Medical Association are contributing financially to our medical school and that in order further to increase the AMA-ERF donation to the University of Hawaii we will have to increase the amount of money raised here.

This committee has no new plans for next year and requests no budget.

DOUGLAS B. BELL II, M.D.

AMA-ERF Committee

Your Committee considered the report of the AMA-ERF Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ARRANGEMENTS

This committee had three formal meetings and Dr. Wiperman, the man on whose shoulders most of the work has fallen, came to Honolulu for two of them.

Hotel Accommodations: Initially 200 rooms had been blocked off by the Naniloa Hotel and it was a great disappointment to us when they advised that this would be cut down to 70 rooms. In addition the space promised for meetings and exhibits did not develop inasmuch as their building activities did not progress as planned. The 70 rooms were reserved for members of the House of Delegates, Arrangements and Scientific Program Committees, staff and guest speakers. The hotel required a deposit of one night's lodging and advised that they would not hold the reservations after April 20. On April 21 they were asked to hold the balance for a few days to enable nondelegates to have the opportunity to book rooms at the Naniloa. Only 26 physicians booked rooms at the Naniloa and the balance of the block was given out to non-MD's. The Hilo Hotel reserved 15 rooms on a first-come first-served basis. All indications are that the Travel Lodge may have rooms available but the question of whether or not their furniture will arrive caused their mainland office to rescind the local agent's offer to book rooms in advance. Despite these problems, registrations for the annual meeting are coming in and the individual doctors appear to have been quite ingenious in securing accommodations on their own—one has rented a trailer!

Exhibits: The original sketch called for 46 booths but this was reduced to 41. Of these 38 were reserved at the time of the drawing for positions. Subsequently three more reserved booths and two withdrew, making a final total of 39 exhibitors.

Meeting Hall: After the space promised by the Naniloa did not develop, arrangements were made to hold all meetings at the KMR National Guard Armory, which was available at a very low rental. We have had excellent cooperation with the National Guard and the Hawaii Protection Assn., which will provide the security services.

Fishing and Tennis: Since these events will be held before the annual meeting begins and since not all the participants plan to go to Hilo, they were spun off from the official events but included in the announcements. They will have their own Sportsmen's Night on the Sunday before the Annual Meeting begins.

Golf: In order to be absolutely certain that the wishes of the majority would be followed, post card polls were sent out to see where the tournament should be held. All but a few stated a preference for Mauna Kea. At one time consideration was given to renting a bus, but the response was not adequate to undertake this project. The exhibitors have been invited to participate in the tourney, but not the prizes, and they have offered transportation to and from the Kamehameha Coast. Only the entrance fee is being collected at the time of registration. Participants will pay their green fees and cart charges at the pro shop.

Sportsmen's Night: Thought was given to holding this in some area close to where the golf tournament is being played. However, suitable accommodations were not available and the committee reverted to the original proposal that it be at the AJA Club House in Hilo. Except that beer will be provided through the courtesy of the Primo Brewery, it will be a BYOB party. The food will be catered.

Breakfasts: These will be catered and it was decided to leave the menu choice up to the caterers.

Banquet: Originally it was decided to hold the banquet at Sun Sun Lau where there are ample accommodations. Subsequently, the banquet was moved to the Hilo Yacht Club. The disadvantage of this location was the limited space, up to 160 people. In view of this limitation, entertainment and dancing will be eliminated.

Aloha Committee: Since many of the speakers will be going direct to Hilo, Dr. Wipperman was asked to form a committee. When their arrival times are confirmed, he will be supplied with the information he needs to make arrangements to meet them.

RECOMMENDATIONS: (1) That in the future no plans be made to hold annual meetings on neighbor islands until the proposed facilities have been completed and are inspected to be certain that they will accommodate the needs of the HMA. (2) That the local arrangements committee members in Hilo be applauded for their fine work and outstanding hospitality. Without them, this meeting could never have been planned or accomplished.

R. VARIAN SLOAN, M.D.

Arrangements Committee

Your Committee next considered the report of the Arrangements Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of the report and all the recommendations.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

ASSOCIATION OF PROFESSIONS

The committee met four times studying a course of action to be taken toward future organization of an Association of the Professions. Because of the committee is small, there has been difficulty in making decisions when there have been absentees. It is recommended, therefore, that three additional committeemen be named. It also is recommended, because of duplication on the county level, that the State committee on an Association of Professions consider merging or meeting together with its county counterpart.

There is no budget request.

RECOMMENDATIONS: (1) That the committee be expanded with the addition of three more members. (2) That consideration be given to merging or meeting together with the Honolulu County Medical Society's Inter-Professional Relations Committee.

LEABERT R. FERNANDEZ, M.D.

Association of Professions

Your Committee next considered the report of the Association of Professions. A full and complete discussion of the subject was had. Your Committee recommends that recommendation No. 2 be amended by striking out the words "merging or." Your Committee further recommends that in the second recommendation the word "Honolulu" be deleted and the word "component" inserted in its place. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

AWARDS

The committee had one meeting this year on March 19, 1969, to discuss the Hawaii Science Fair and nominations for the Robins Award.

Hawaii Science Fair: The Hawaii Science Fair was held April 10-13, 1969, at the Hilton Hawaiian Village Dome. The HMA supported this Fair and extended six

awards of \$15 each. The judges representing the HMA were Drs. William J. Holmes and Robert A. Nordyke. The recipients of these awards are as follows:

"The Effects of Paint and Glue Sniffing"

1. Clifton Liu
 2. Edward Tateishi
- } Kaimuki Intermediate

"Poisonous Plants"

1. Adeline Camacho
 2. Pauline Takahashi
- } Waiakea Intermediate—
Hilo, Hawaii

"Ecological Study Applicable to Planetary Space Travel"

1. Todd Lisenmeyer—Maryknoll High School

"The Effects of Drugs on Chicken Embryos"

1. Charles Lewis—Kohala High School

"Planeria Regenerative Properties"

1. James Black—Hawaii Preparatory Academy

"The Effects of Acids and Alkalines on Teeth"

1. Steven Kanemoto—Farrington High School

The committee is continuing its association with the Inter-Society Science Education Council (ISSEC) of the Hawaiian Academy of Science and Associated Societies, and your chairman is the HMA representative.

Robins Award: At this meeting, the Robins Award winner was chosen.

BUDGET REQUEST:

Prizes	\$ 90.00
Contribution	100.00

TOTAL..... \$190.00

ROBERT A. NORDYKE, M.D.

Awards Committee

Your Committee next considered the report of the Awards Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

CAREERS

During the past year, the committee has attempted to continue to increase its activities and responsiveness to the medical profession and to the community regarding the increasing requirements of the health professions.

Meetings were held almost monthly. On February 21, 99 high school students participated in a Careers Day. Prior to this activity, a meeting was held with school counselors explaining our program and our willingness to participate in any careers planning at the high school level and showing the exhibit which had been made for the Health Fair.

University Careers Day was held at the University of Hawaii and the HMA participated with a booth. Approximately 25 personal interviews were held with students and although we did not reach many students, those that we did were highly motivated towards medicine.

We have also had a number of discussions with the medical school and I feel this participation has given added incentive to University counselors to do a better job of pre-med counseling.

The participation by the doctors at the Careers Booth of the Hawaii Medical Association at the Health Fair was worthwhile and the use of the exhibit with automatic slide projections was well received. New slides have been obtained of this year's Careers Day Program which will be utilized in further exhibits. These will have more local interest and will include local students and doctors.

The Woman's Auxiliary has made up a Health Careers Chart, which is very helpful and will be utilized further in the future.

Future activities include a Careers Day Program in which all health professions that are interested will be

represented. It is hoped that the Woman's Auxiliary will consider taking this as their project and developing it with the other health professions.

The doctors should continue to be interested and participate in the medical careers part. It is our hope that the various counties will take a more aggressive approach to hold the Careers Program for high school students in their own counties.

Further meetings are scheduled to contemplate planning a Health Professions Careers Day Program in October to complement Community Health Week.

BUDGET REQUEST:

Air fare for participating students.....\$275.00

RECOMMENDATIONS: (1) That the Woman's Auxiliary be asked to embark on a project to hold annual Careers Day Programs for all health professions and that this project be developed in cooperation with the other professions. (2) That the next committee consider the suggestion of the counselors and hold the annual program for medical careers on a school day. (3) That the various counties be encouraged to take a more aggressive approach to holding careers programs for high school students in their own counties.

H. WILLIAM GOEBERT, JR., M.D.

Careers Committee

Your Committee next considered the report of the Careers Committee. A full and complete discussion of the subject was had. Your Committee recommends striking out the word "embark" in the first recommendation and the word "assist" be inserted in its place. Your Committee recommends further amendment to this recommendation by inserting after "professions" the words "including medicine, nursing, and paramedical personnel." Your Committee further recommends deleting recommendation No. 2 and substituting the following recommendation: "That a student critique of the next Careers Day include a question asking them if they would prefer a school day." Your Committee recommends approval of the report and its recommendations as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

DISASTER

The entire committee held no formal meetings during this year. The necessary work during the year was done by committee members on an individual basis.

The major disaster medical programs for this year were as follows: (1) Medical Self Help. (2) PDH (Package Disaster Hospitals). (3) Emergency Medical Stockpiling. (4) Health Fair Disaster Exhibit.

The Medical Self-Help Training Program which is a comprehensive First Aid Training Program for disaster survival is now in its seventh year in Hawaii. Since records were first installed in March, 1963, the Medical Self-Help Program has, through December, 1968, totaled 43,801 graduates.

Three major disaster exercises were held on Oahu during the calendar year 1968. Exercise 417 by far the best exercise ever held on Oahu was held at the Honolulu International Airport on May 1, 1968. During this exercise, 350 simulated casualties were processed. An exercise entitled HAWDEX 68' was held on October 17, and ERMA was held in Berkheimer Tunnel on October 30. The Hawaii Health Fair, October 11-13, disaster exhibit also included three exercises, one held each evening and sponsored by three of the major Oahu hospitals.

We now have 19 PDH's; 16 are federally owned stockpile, two are training hospitals federally owned, and one is a State owned hospital. Eleven of these are on Oahu, one is on Kauai, two on Maui, and five on Hawaii. A new Task Force Program to evaluate the medical stockpile for Hawaii was established by the State Health De-

partment in April, 1969. Dr. Quisenberry has appointed me as Chairman of this special Task Force.

RECOMMENDATIONS: (1) That all county societies update their disaster plan and medical manpower assignments at least annually. (2) That county societies and major hospitals on neighbor islands hold at least one disaster exercise per year. (3) That the HMA enlist its members in planning for the establishment of a new medical stockpile for Hawaii through the Special Task Force so designated.

CASIMER JASINSKI, M.D.

Disaster Committee

Your Committee next considered the report of the Disaster Committee. A full and complete discussion of the subject was had. Your Committee recommends that recommendation No. 2 be amended by inserting the word "all" after the word "that," and that the words "on neighbor islands" be stricken out. Your Committee further recommends that the chairman of the Disaster Committee establish better communication and a closer working relationship with the neighbor island disaster planning groups. Your Committee recommends approval of the report and its recommendations as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

FILIPINO SPEAKERS BUREAU

The committee had one meeting and plans were made for initiating the activities. It was felt that the programs should be scheduled on radio in the early morning hours. The radio stations are willing to do this but it means they will have to be taped because it would be too much to ask the doctors to appear in person at 4:30 A.M. The taping has not yet been accomplished. The members plan to gather after one of the County Society meetings and finalize plans for these programs.

Mr. Respicio of Channel 2 has been approached for time on television. He advised that he would take this up with the manager but as yet he has not been heard from. There is no budget request.

CORAZON A. MANAYAN, M.D.

Filipino Speakers Bureau

Your Committee next considered the report of the Filipino Speakers Bureau. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

JAPANESE SPEAKERS BUREAU

The Bureau consists of twelve regular members who appear on KOHO Radio Station every Monday evening between 7:10 and 8:00 P.M. The speaker introduces a topic for about ten minutes and then the program is thrown open to the listeners. The program is heard on all the islands and has wide appeal. The Tuesday afternoon program between 1:30 and 2:00 P.M., which was discontinued after six months, was restarted by popular demand in November. Since other members have difficulty appearing on this afternoon program, the regulars have been Drs. Yamashita, Goshi, Akagi, Natori, and Yokoyama. This afternoon program is heard by yet another segment of the Japanese speaking population and has been equally popular judging from the telephone response. During the year, the Bureau met twice with officials of KOHO and *Hawaii Times* to plan the format and the schedule. It met once in the HMA office for a business session. During the year, it cooperated with the diabetes drives, the Health Fair, and the World Leprosy Day.

TAKAKAZU FUKUMURA, M.D.

Japanese Speakers Bureau

Your Committee next considered the report of the Japanese Speakers Bureau. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION :

The Chairman moved adoption of this portion of the report. It was adopted.

MEDICINE & RELIGION

The purpose of this committee is to foster mutual familiarity between clergy and doctors to effect better total patient care. I attended the fourth regional meeting for State Chairmen, where the various stages of accomplishing the ultimate goal of "Better Total Patient Care" were discussed. The AMA review committee looked with favorable light on the committee as having a positive public image with favorable publicity and more effective patient care. Planned for the future is a Honolulu County Medical Society meeting on June 3 with Dr. John G. Finch, Ph.D., as guest speaker and Dr. Paul McCleave, director of AMA's Medicine and Religion division, to make appropriate comments. Also planned are some neighbor island meetings with Dr. McCleave in June.

BUDGET REQUEST:

Travel	\$200.00*
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FRANCIS H. SOON, M.D.

* Deleted by the House of Delegates.

Medicine and Religion Committee

Your Committee next considered the report of the Medicine and Religion Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of the report with the deletion of the budget request.

ACTION :

The Chairman moved adoption of this portion of the report. It was adopted.

MESSAGE OF THE MONTH

The committee continues to write and distribute monthly health care messages. Four of these messages, those preceded by an asterisk, have been subsidized by voluntary health agencies.

Messages for the year 1968-69 are as follows:

1968	
May	Family with Pets
June.....	People with Hearing Problems
July.....	Overweight and Over 40
August.....	Dizzy People
September.....	People with Pimples
October.....	People who are Exposed to the Flu Bug
*November.....	Those who Smoke
December.....	New Mothers of 1969 (and beyond)
1969	
*January.....	Hawaii's Hearts
February.....	Those interested in a Rewarding Career
*March.....	People interested in Living Longer
*April.....	People who Suffer with Arthritis

Meetings have been held with the Woman's Auxiliary Committee wherein mutual problems have been discussed and solved. The Committee feels this to be a worthwhile project and requests continued support of the House of Delegates.

At the joint meeting with the Woman's Auxiliary Committee it was suggested that perhaps boxes could be

placed in doctors' offices to hold the Messages. They also wanted to explore the acceptability of having posters placed in the doctors' offices. A post card poll was made to find out how many doctors would be interested. Eighty-three indicated they would like to have the boxes. The same number asked for posters. Generally speaking, those who wanted holders indicated they would also like posters.

It is estimated that each would cost perhaps a dollar apiece, but this estimate could vary considerably depending on the quality required.

BUDGET REQUEST:

Messages	\$2,350.00
Boxes	100.00
Holders	100.00
TOTAL	\$2,550.00*

WILLIAM F. MOORE, JR., M.D.

* Changed to \$1,250.00 by the House of Delegates.

Message of the Month Committee

Your Committee next considered the report of the Message of the Month Committee. A full and complete discussion of the subject was had. Your Committee recommends that the report be accepted.

Your Committee further recommends that the newspapers be explored as a means of publishing the monthly message of the month as a public service. Your Committee recommends approval of the report with this added recommendation.

ACTION :

The Chairman moved adoption of this portion of the report. There were objections.

It was moved and seconded not to adopt this portion of the report but to amend the report as follows: "Your Committee further recommends that the newspapers be explored as a means of publishing the monthly message of the month as a public service, and that the Committee solicit support of the voluntary health organizations to assist in reducing its budget. The motion was defeated.

It was then moved and seconded to reconsider the original motion since the Bylaws specifically state that "The Message of the Month Committee shall develop and solicit funds for the dissemination of monthly messages to promote health education." It was voted to reconsider the original motion that this portion of the report be adopted.

It was moved and seconded to amend the motion that the report be amended to read: "That \$2,500 be appropriated for the purpose of the message of the month and encourage those responsible to seek outside sources of funding." This amendment was defeated.

It was moved and seconded to amend the motion that the report be amended to read: "That \$1,250 be appropriated for the purpose of the message of the month and encourage those responsible to seek outside sources of funding." This amendment was passed.

The Chairman moved adoption of this portion of the report as amended. It was adopted.

NEWS MEDIA

The committee continued its liaison during the year with newspapers, television, and radio stations.

No medical series are appearing regularly under HMA auspices at the moment, but the *Star-Bulletin* has several pilot articles it intends to print in series as soon as some organizational problems are solved. Dr. Rowlin Lichter has written several such articles and others have been prepared by other physicians, awaiting inauguration of the series. Other contributors include Dr. C. Caver,

Dr. E. E. Devcreux, and Dr. F. E. Pope.

The educational TV series will be off the air from June 18 to September 3. The committee will maintain the weekly medical health releases written by Hugh Lytle, choosing timely subjects.

The chairman of this committee guided a new science writer for the *Advertiser* on a tour of clinics and hospitals recently, as an orientation device. This will be done whenever necessary.

The annual medical writers' contest continues to be successful. A small increase in our budget is due because of the higher price of trophies and engraving. A modest increase ought to put us on the safe side.

A tea house party for the news media was held on May 9. This offered an opportunity for free exchange between the press and the physicians. It is hoped that this will be an annual affair and in time there will be greater understanding between the two groups.

A subcommittee has been appointed to explore the possibility of establishing with the hospitals a joint code of cooperation.

BUDGET REQUEST:

Engraving of perpetual trophy.....	\$ 10.00
Cash Award (first).....	150.00
Trophy (first).....	40.00
Engraving of Trophy (first).....	20.00
Cash Award (second).....	50.00
Trophy (second).....	10.00
Entertainment of News Media.....	150.00
<hr/>	
TOTAL.....	\$330.00

HENRY N. YOKOYAMA, M.D.

News Media Committee

Your Committee next considered the report of the News Media Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

NURSES LIAISON

The committee's function is to endeavor to aid the nursing profession with its problems pertaining to better patient care, relations with hospitals and physicians, nursing legislation, and nursing education. An equally important purpose of this committee is to attempt to keep physicians informed of the changing and expanding roles of nurses as members of the health-care team. In our State, the committee fulfills a third major need, that of serving as a unique meeting place and providing a forum where representatives of the medical profession meet with members of the nursing profession on a regular basis. These nurses participate as official representatives of the following organizations: Hawaii Nurses Association, Hawaii League for Nursing, University of Hawaii, School of Nursing, and Hawaii Hospital Association, plus an additional representative closely associated with an ongoing study concerning delineation of roles of levels of nursing personnel.

During the past year the committee was concerned with the following activities:

1. Information regarding the joint statements on intravenous therapy, closed cardiac resuscitation, and acute cardiac care and the role of the nurse was disseminated to appropriate organizations and institutions, and a publicity release in the newspapers was obtained. Consideration of an additional joint statement on the use of plastic catheters for intravenous therapy was discussed and it was felt that the joint statement on intravenous therapy included the use of plastic catheters.

2. In the manner of the wording of the Public Health Regulations regarding immunizations, the committee objected to the wording of "medical technician" in the text of the Public Health Regulations. The committee voted

to ask the HMA Council to request of the Department of Health that the words "properly trained" be inserted in Chapter 7 of their Public Health Regulations to modify the phrase "paramedical personnel."

3. The subject of nurses substituting for pharmacists in the dispensing of drugs at all levels was discussed at length at nearly every meeting of this committee this year. Immediately prior to the meeting at which the chairman of the Hawaii Pharmaceutical Association's Legislative Committee was invited, the HMA Council at its January 22 meeting voted that this subject was a matter between the nurses and the hospitals, and the nurses and the pharmacists. The representative of the Pharmacists Association will pursue a dialogue with members of the nursing profession on this matter. No official stand was taken.

4. During the year a progress report on the "Demonstration Unit," a part of the five-year project entitled "A Multiphasic Approach To Program Enrichment" was submitted to the Committee. A news release was formulated as a result of this progress report, however, the material never reached the newspapers.

5. The possibility of having Nurses' Recognition Day was discussed and the concept was approved.

6. The following pieces of legislation were considered: (a) HB 707, changing the composition of the Board of Nurses. Nurse Liaison Committee supported the Board of Nurses in its opposition to this bill. (b) HB 951, lowering current licensure requirements for LPN's. The committee went on record as opposing this bill. (c) HB 952, proposing to replace registered nurse members of the Board of Nursing with lay members. The committee expressed opposition to this bill.

7. The new Dean of the University of Hawaii School of Nursing, Dr. Edith Anderson, was introduced at the final meeting in 1969 and she has expressed an eager interest to participate in future meetings of this committee.

There is no budget request.
H. H. CHUN, M.D.

Nurses Liaison Committee

Your Committee next considered the report of the Nurses Liaison Committee. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

REPORT OF OPERATION PACIFIC

One meeting was held during the year. Problems have been storage, packaging, and shipment of supplies.

One large shipment was sent to Western Samoa via "Federal" air transportation. A general shipment from the stockpile to Tonga was by a Tonganese ship.

At the present moment we have some general medical supplies (not medications) on hand and about \$4,400 worth that must be picked up from a distributor soon in order to make these available to us.

RECOMMENDATIONS: (1) That the HMA provide to the committee some aid in acquiring storage space that may be used to stockpile supplies as they are given to us and provide a location where we will be able to package these items for shipment.

T. H. RICHERT, M.D.

Operation Pacific Committee

Your Committee next considered the report of the Operation Pacific Committee. A full and complete discussion of the subject was had. Your Committee recommends amending the recommendation by striking out the word "provide" and inserting the word "assist." Your Committee further recommends striking out the words "some aid." Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS

The committee met monthly and a report was received from Dr. Herbert Uemura regarding the annual AMA Public Relations Conference which he had attended. It is my opinion that money should be continued to be allotted in the Budget for this Conference and that deserving physicians should attend, if feasible. I do not feel that it is a necessity that someone attend every year. I felt the main thing gained from this conference was that of increasing awareness in the medical profession that the doctors must become involved in an active way in medical planning for the community.

In response to some of this type of discussion, the committee and the Bureau of Research and Planning met with various labor leaders during the year in an informal way trying to discuss the public's needs and wants as far as medicine is concerned. This was done to improve doctor-public relations. We also attempted to improve doctor-patient relations by sending out a questionnaire which was very well received and will require further tabulation in the future.

We have initiated, but have not yet started, a Physician's Message of the Month. This is to help doctor-doctor relations and doctor-patient relations and it will be sent to doctors only and will include pertinent reminders.

We held on May 9, a news media-doctor meeting in an informal manner. This has been done here previously and has met with good response. It allows the doctors and the press to become more informal with one another and thereby avoid some of the difficulties with our relationships with the press and with other communications media.

Suggestions for the future: We suggest that there be a consideration of a newsletter or public relations report sent to all members of the Hawaii Medical Association monthly or every two months which will attract the eye and which will also inform the members as to the various actions being taken in other committees. It is the feeling of the committee that this will improve doctor-doctor relationships and further strengthen the ties of the doctor to the Hawaii Medical Association. It is the feeling of some of the members of the committee that lack of communication among the physicians in the HMA is one of our weaknesses and this type of communication can be utilized to strengthen the Association because with knowledge there is strength. The publication will have to be more than just another mimeographed sheet in order to be effective. We are, therefore, asking for \$1,000 to get the publication started.

We feel that we should continue to be responsive to patients' needs and wishes and it is hoped that the Physician's Message of the Month will be helpful in this regard.

We would recommend that further questionnaires be sent to the doctors in an attempt to ascertain their feelings regarding the strengths and weaknesses of the Hawaii Medical Association and where more or less emphasis should be placed on differing projects.

We feel that the press-doctor meeting should be an annual event.

BUDGET REQUEST:

Conference expense	\$ 550.00*
Counsel	6,000.00
Newspaper advertisements	100.00
Dues	15.00
Miscellaneous flyers	175.00
Printing	50.00
Doctors' Message of the Month.....	100.00*
PR Bulletin to members.....	1 000.00*
Miscellaneous	100.00
TOTAL.....	\$8,090.00

RECOMMENDATIONS: (1) That a monthly message be printed and distributed to each member physician. (2) That a printed PR bulletin be sent out monthly to all members to inform them of the various actions being taken in committees. (3) That questionnaires be sent to doctors to ascertain their feelings regarding the strengths and weaknesses of the HMA and the results be used as a guide to future activities.

H. WILLIAM GOEBERT, M.D.

* Deleted by the House of Delegates.

Public Relations Committee

Your Committee next considered the report of the Public Relations Committee. A full and complete discussion of the subject was had. Your Committee recommends the deletion of the following items from the budget: Conference Expense (\$550.00); Doctors' Message of the Month (\$100.00); and the Public Relations Bulletin to members (\$1,000.00). Your Committee further recommends that recommendation Nos. 1 and 2 be deleted. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

QUACKERY

Since the last annual report, the committee has met twice. The first was a meeting called at the request of Mr. Billam-Walker of the Better Business Bureau to check on the validity of claims that a health pillow emitted radioactive rays which ran the gamut of curing everything from spoiled meat to arthritis. The pillow was opened in the presence of the committee; a representative of the Department of Health was present with a Geiger counter. The material in the pillow emitted no measurable radioactivity. Mr. Billam-Walker stated he would take whatever appropriate action was necessary.

The second meeting covered four topics. The first was regarding the Ever-Young Way of facial rejuvenation, which was found to be a medically old and a fairly good treatment, but which was also found to be exorbitantly priced and unethically promoted. The second item was psychic surgery in the Philippines which was discussed by a rather erudite individual who has witnessed Tony Agpao in the performance of his "surgery." Although the witness spoke in a rather convincing fashion, it was the general feeling of the committee that such "surgery" is utterly fraudulent. Unfortunately, however, the HMA has no jurisdiction over the Philippines.

Item number three was a discussion of the "Maru Health Pillow" which was being marketed in Honolulu by a retired dentist. The health pillow was actually made with three rods in a triangular fashion upon which one rests the affected part. The advertising for this pillow was very carefully worded and there appears to be no violation of existing laws.

Item number four was Papaya Foods of Hawaii which are being used, among other things, as a cure for asthma. This has been referred to the Department of Health for action.

RECOMMENDATIONS: (1) That the committee continue to function as outlined in the HMA Bylaws. (2) That a program be developed to help combat the impact on the public of the Chiropractic Meeting scheduled for June, 1970.

WILLIAM H. SAGE, M.D.

Quackery Committee

Your Committee next considered the report of the Quackery Committee. A full and complete discussion on the subject was had. Your Committee recommends the approval of the report with the deletion of recommendation No. 2.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

SCIENTIFIC PROGRAM

The committee has chosen as its topic for this year Cardiopulmonary Disease and has tried to include the varied topics in this field from air pollution to office cardiac disease.

This year's format, since the meeting is being held on the Island of Hawaii with an estimated smaller attendance than if it were held on Oahu, utilized all lectures with no roundtable discussions. The two-hour lecture sessions were scheduled for Wednesday morning and evening, Thursday morning and evening, Friday morning, and Saturday morning.

Grateful acknowledgment is made to the following organizations who contributed amounts making this program possible: Hawaii Heart Association, \$1,000; Eli Lilly Company, \$500.00; Parke, Davis & Company, \$250.00; Ciba Pharmaceuticals, \$300.00; Ortho Pharmaceuticals, \$250.00; Schering Corporation, \$250.00, and S. E. Massengill Company, \$50.00. The following organizations have subsidized speakers: Hawaii Thoracic Society and Merck, Sharp & Dohme.

Since the lecture series is being held in Hilo, there has been active interchange of lecturers between the islands in order to provide greater educational benefits to those who are not able to attend the Hilo meetings.

The registration fee for the HMA members is waived in order to encourage attendance to the meetings. Since the last House of Delegates meeting, registration fee for nonmembers was raised from \$35.00 to \$50.00.

RECOMMENDATIONS: (1) The committee start planning soon after the appointment is made by the next president. (2) The possibility be explored of having over-all medical continuing education program for physicians incorporated with the Scientific Program Committee, utilizing the various governmental agencies such as the Regional Medical Program and Comprehensive Health Planning.

LIVINGSTON M. F. WONG, M.D.

Scientific Program Committee

Your Committee next considered the report of the Scientific Program Committee. A full and complete discussion on the subject was held. Your Committee recommends approval of the report.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

TV-RADIO

The members of this committee have continued with their hard work in producing the "Medically Speaking . . ." program on KHET-TV. They should be commended for their untiring efforts. The format of the "Medically Speaking . . ." show has remained essentially the same since its inception in January of 1967 under the illustrious leadership of the former chairman Benjamin C. K. Tom, M.D. Mr. Nick Carter, KHET-TV producer-director, has been especially helpful in keeping up the quality of the shows. His extra efforts in providing appropriate film clips for many of the shows has been most appreciated.

The show was preempted on several occasions during the political campaigns last November. Again, the show was asked to give way to "The Messiah" on Christmas night. However, the show came back on schedule on New Year's night.

A highly successful innovation during the past year was a program on diabetes mellitus presented by a panel of Maui physicians, with questions coming from the people of Maui via Dr. Bjornson, acting as "Maui

Question Central." The committee members all felt that this was a worthwhile venture and outside island participation is again strongly urged for future programs.

Mr. Gordon Burke, our faithful moderator, Mr. Hugh Lytle, "Question Central," and Mr. Patrick Godfrey are all deserving of special commendation for their efforts.

KHET has asked "Medically Speaking . . ." to take a "summer break" this year. This should come as a welcome relief for all involved with the production. Also, this interlude should afford some time for the new chairman and members to get "tooled up" for a new season.

BUDGET REQUEST:

Weekly salary for Gordon Burke at \$35.00 a program based on 40 weeks	\$ 1,400.00*
Miscellaneous	100.00
Refreshments	200.00
Sunday ads	440.00
Transportation	300.00
TOTAL.....	\$2,440.00

* Increased to \$1,600 by the House of Delegates.

RECOMMENDATIONS: (1) That HMA continue the ads in the Sunday TV Guide. (2) That Mr. Burke's salary be increased by \$5 for each show. (3) That enough money be allocated to pay for transportation of panelists from neighbor islands for participation on "Medically Speaking . . ." (4) That a sum equal to \$5 per show be allowed for reimbursing the chairman's expenses incurred in providing "refreshment" for the panelists after the performance. (5) That the schedule of programs be more widely publicized to all interested groups.

HERBERT UEMURA, M.D.

Television-Radio Committee

Your Committee next considered the report of the Television-Radio Committee. A full and complete discussion on the subject was had.

Your Committee recommends approval of the report with an increase of the first item in the budget from \$1,400.00 to \$1,600 to reflect the \$5.00 increase for Mr. Burke.

ACTION:
The Chairman moved adoption of this portion of the report. It was adopted.

WOMAN'S AUXILIARY

In the past year there has been a great increase in the activity of this Advisory Committee to the Woman's Auxiliary both through the President of the State Society, Mrs. Varian Sloan, and through the President of the Honolulu County Society, Mrs. Donald A. Jones.

The initial meeting of this committee was on Tuesday, October 29, 1968, at which time the perennial problem with delivery of the "Message of the Month" by the women of the Woman's Auxiliary was discussed. The entire problem was reviewed with a larger number of committee members present than had been previously present in the last two years along with representatives of the Woman's Auxiliary. It was decided that additional information should be obtained by the State and County Society chairmen in charge of community services, Mrs. Jerome Tucker and Mrs. George Kimata.

At a second meeting of this committee on January 28, 1969, the report of the medical "Message of the Month" survey was presented by the women of the Auxiliary. After a great deal of discussion it was the opinion of the Woman's Auxiliary Advisory Committee that a thorough study of the entire Message of the Month problem by the appropriate committee was in order. It was this committee's feeling that the number

of volunteer hours required for delivery of this message was not worth the benefits that seem to be incurred from its delivery. This entire problem then with this recommendation was referred to the Message of the Month Committee, as well as the Commission on Public and Interprofessional Relations. Some meetings and actions have been taken on this proposal, and you are referred to the reports for the details.

A third activity in the committee revolved around a luncheon honoring the women of the Auxiliary who have assisted in the Message of the Month Program. This money was allocated to the Woman's Auxiliary Advisory Committee. Earlier in the year, the women of the Auxiliary suggested that there was a much better use for this money and they requested use of the money by the Women's Auxiliary for purchase of a film on marijuana rather than the luncheon. By action of the council on October 23, 1968, this was determined to be a House of Delegates appropriation and that the Council could not change its designated use. The chairman of the Message of the Month Committee was then requested to proceed with plans for the luncheon.

The final order of business of the Woman's Auxiliary Advisory Committee of the HMA was to review with the state officers a request for an increase in the HMA allotment to the Woman's Auxiliary of \$10 per doctor instead of \$5. This request was supported by very fine presentation by Mrs. Howard Liljestrand and Mrs. Charles K. Yamashiro, who are members of a special finance committee of the Woman's Auxiliary appointed by Mrs. R. Varian Sloan. This request was presented and approved by the Advisory Committee, and it was decided that these women should review this for the Council and possibly the House of Delegates or the Reference Committee at the annual meeting.

There is no budget request.

RECOMMENDATION: That next year's committee initiate a meeting or at least contact the officers of the State Woman's Auxiliary early in the fall.

DONALD A. JONES, M.D.

Woman's Auxiliary Committee

Your Committee next considered the report of the Woman's Auxiliary Committee. A full and complete discussion on the subject was had. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

HAWAII MEDICAL JOURNAL

The JOURNAL has had few changes in the past six issues. One new feature was added at the suggestion of the Hawaii Radiological Society: entitled *X-Ray View Box*, it is written by members of that group in rotation, and has drawn no criticism in its three appearances to date. One old feature, *This Is What's New*, which had to be given up by Dr. Fred I. Gilbert, has been resumed under the title *Slants and Angles*, with the authorship of Dr. W. Philip Jones and a slightly altered format.

Average number of pages per issue has remained close to 100, with 48 pages of one issue devoted to a report of the Cancer Registry, which subsidized its publication, and 57 pages of another to the annual meeting transactions. Advertising is still pretty low, below both 1967 and 1968, with an average of nine pages of local and 37 of mainland ads; the average of mainland ads in the past three issues, however, is almost 41 pages, so we may be improving. We are in almost continuous planning with State Journals West in an effort to improve this important source of funds.

Twenty-four original articles have been published this year; four have been rejected as unsuitable, and four have been extensively rewritten in accordance with specific

requests, and then accepted for publication. We are running about six or eight months between receipt of manuscripts and publication.

No assistant editor has yet been found; applications for the position are solicited. The position would be far easier to fill if it did not involve, as it now must, editing of manuscripts. We still need a professional manuscript editor, too, but have not found one. This need also becomes increasingly urgent, though it won't (I hope!) be critical until about 1980 or so.

Reviews were published for 50 books and capsule comments on books "also received" for 19—50 less, mysteriously, than in the previous year. The dollar value to the Library, to which they were all donated, was \$861.00. HMA members were asked if they wished to review books for the JOURNAL; 97 said no and 117 said they would be happy to do it.

I would recommend the continued publication of the JOURNAL during the coming fiscal year on the same basis as heretofore..

HARRY L. ARNOLD, JR., M.D.

Editor's Report

Your Committee next considered the report of the Editor of the HAWAII MEDICAL JOURNAL. A full and complete discussion of the subject was had. Your Committee recommends approval of the report.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

MAUI

The year 1968 began with major revisions of the By-laws. Ten high school students from Maui County attended the Careers Day program in Honolulu. This program will probably have to be transferred to the Boy Scout program with establishment of a Medical Explorer Post.

The Society undertook the responsibility of the Diabetes Screening program this year and will continue annually.

Much thought was given to osteopathic medicine, culminating in a resolution adopted June 18, 1968, essentially advocating a common examination for doctors of medicine and osteopathic physicians. The issue will be pursued in 1969.

Hale Makua Home Nursing Service is to begin in January, 1969, with the full support and cooperation of the Society as partial answer to improving medical services on Maui.

An offer for a pilot study for Continuing Medical Education from Regional Medical Program, Hawaii, was accepted by the Society, details to be worked out in early 1969.

The medical community continues to enjoy favorable relationship with the local press and radio except for few isolated items which call for continued communication.

Foreseen for 1969 are problems related to health hazards, particularly in reference to but not limited to increasing "hippie" population, and complete State takeover of Act 97 hospitals.

SAKAE UEHARA, M.D.

HAWAII

In 1968 the Hawaii County Medical Society ambled along much the same as it has for many decades—a small society (of about fifty members) with few changes in membership from year to year. Meetings were sedate affairs attended by fifteen or twenty members. Such debate as there was hardly ruffled the waters. The members who attended the meetings were happy to have their insularity relieved temporarily by the generally excellent guest speakers.

HAROLD LEWIS, M.D.

HONOLULU

The year of 1968, with the usual pattern of accelerating activity and expanding programs, brought new and enlarged old problems to the attention of the officers and the membership.

The newly created Community Health Planning Committee in close cooperation with the Health Department did succeed in setting up a program for the Leeward coast area. (Actual implementation took place in 1969.) It is specifically mentioned because of the very great import that it may have on future activities. This was our first embarkation into the field in conjunction with a public agency. More of this action type program may be anticipated for the future.

Relationships with all types of community planning were explored during the year. The School of Public Health, Office of Economic Opportunity, Model Cities, Comprehensive Health Planning (PL 89-749), and others were engaged in the same activities. It was necessary that new policies be established and new ideas be explored. Our ultimate future participation both as to direction and depth in such planning has yet to be determined.

Reorganization of the multiple corporate structure of the County Society has not been completed. The many problems relating to this have not been resolved.

Staffing of the Foundation for Medical Care continues to be a major problem because of the inadequate income to the Foundation from the insurance carriers. This matter is being explored in considerable depth by the Society and the Foundation. The Foundation is an activity much to be desired and is deserving of serious support but also must be able to meet its operating costs in the foreseeable future.

Medical Plaza, Inc., encountered new obstacles with the change in the City-County Administration. Negotiations for the parking space have not been productive to date.

Problems relating to the direction and function of the Health Fair are being considered by the Board of Governors. The Health Fair held in October played to over 100,000 persons and operated with a budget of well over \$100,000. The future of the Health Fair is a major concern of the Board of Governors.

Routine activities of the Society in Disaster Planning, Medicare Review, Utilization Review, etc., continued as usual.

The Society continued its effective work with the Medical Practice Committee. Other committees were equally functional.

It would seem that the changing socio-economic picture is occupying a larger and larger proportion of the time and attention of the Society. Routine activities seem to be pushed into the background. Problems facing us are those of the continued development of our post-graduate programs because of the reduction in funds available for sponsorship by the various drug companies. The approaching change in the DSS program under Title XIX of the Social Security Act threatens the teaching programs in the hospitals. It also poses a real test of our medical manpower.

Bylaw changes relative to the classification of membership and the opening of our membership to those holding Temporary and Limited licenses may broaden our base and strengthen our position as representing the profession. Dues to the membership appear to be approaching a reasonable limit. It is imperative that the Society consider the areas in which they can establish priorities that can be supported within our financial capabilities.

The Bureau of Medical Economics went through a difficult period of reorganization but is now firmly established as a solid and important element in the Society field of activities in the economic area. Aside from its collection activity, it performs a badly needed function in the training of office personnel for physicians and consulting on business practices.

The Honolulu County Medical Society has kept abreast of current developments and has become an active participant in community affairs in matters relating to the practice of medicine. It intends to continue this function of reviewing and recommending in regard to all programs affecting the private practice of medicine.

K. S. TOM, M.D.

Honolulu, Maui and Hawaii County Reports

Your Committee next considered the reports of the Counties and noted that no report was received from Kauai County. A full and complete discussion of the subject was had. Your Committee recommends approval of these reports as received.

ACTION :

The Chairman moved adoption of this portion of the report. It was adopted.

PUBLIC RELATIONS COUNSEL

Public health education continues to be a most successful facet of physicians' activities. Pre-planning of the next season's educational TV programs over the KHET network is already under way. The current series ends June 3. This gives the KHET-TV staff time for needed vacations. Physician participants need a rest as well. The programs resume on Aug. 3.

KHVV-TV has begun using the HMA press releases on various health subjects as weekly features. This station has put news coverage on an all-day basis and our health features find ready acceptance there.

Doctors of Hawaii can expect pleasant news when the results of the current survey of patient reaction is summarized. From the looks of things, hundreds and hundreds of patients believe doctors are competent, considerate, and concerned with patient welfare to every instance of belief to the contrary. And where criticism is voiced, some real lessons are to be learned.

There is room for many younger physicians in the several committees dealing with press, radio, and TV. Any doctor who is a frustrated journalist, publicist, or has ambitions to take part in television, is hereby urged to volunteer for service on such committees. The Old Guard is competent but getting older.

HUGH W. LYTLE

Public Relations Counsel

Your Committee next considered the report of the Public Relations Counsel. A full and complete discussion on the subject was had. Your Committee recommends approval of the report.

ACTION :

The Chairman moved adoption of this portion of the report. It was adopted.

PRESIDENT, WOMAN'S AUXILIARY

The Woman's Auxiliary to the Hawaii Medical Association has just completed its 20th year of pursuing its main objectives, namely: "To assist the Hawaii Medical Association in its program for the advancement of medicine and public health." This has required involvement of time and talent for many of its members. We feel a sense of achievement and fulfillment but there is much to do. We must continue even more the efforts in this direction for those who follow us this coming year. My sincere thanks to my Board of Directors, the component auxiliaries, members, and members-at-large for making this year as president a most rewarding experience. We are especially grateful for the guidance and cooperation of our Past President, Mrs. Charles Yamashiro, and the ever willing hands of Mrs. Howard Liljestrand, Mrs. Harold Kimata, and Mrs. Homer Benson.

We appreciate very much the financial assistance which the HMA has provided us to make this a 100 per cent participation membership so that we are free

to call on any doctor's wife to assist us in our programs and projects. Many who have started out reluctantly have become the backbone of our group. We appreciate too, the invaluable assistance we obtain from the Woman's Auxiliary to AMA. The President and President-elect attend an annual three-day conference in Chicago in which the meetings are programmed to assist and train us in preparing and conducting meetings (this year it included a seminar on public speaking and TV presentation). The following week a Workshop is held for the Western Region to which the President-elect is invited and, this year, five committee chairmen. National pays the travel fare to the Workshop. Each of these Chairmen receive excellent training, workshop portfolios, and packaged programs to take back to her Auxiliary. This exposure to the National level gives a challenge to the chairman which will be transmitted to her component auxiliary chairmen.

Our Hawaii Medical Association Advisor, Dr. Donald Jones, and his committee have been most cooperative and interested whenever we have called on them for advice or assistance.

Our National President, Mrs. Karl Ritter, was with us for our 1968 convention. The following week we held a Guest Day in Hilo, Hawaii, "Charting a Course for Health Education" inviting forty civic women club leaders, as our guests, plus the Auxiliary members. This was held at the Hilo Hospital and the films *LSD—Insight or Insanity*, *Dance Little Children Dance* (venereal disease), and *Pulse of Life* (life saving) were shown. They were followed by a demonstration of mouth-to-mouth resuscitation with a doctor in attendance. The Auxiliary members and doctors were most cooperative and the hospital facilities excellent. Luncheon was served after which Mrs. Karl Ritter was our guest speaker. A packet consisting of brochures and literature to assist in health related programs was given to the guests.

Our Editor for "RX for Doctors' Wives," Mrs. William Natoli, has received national recognition for her excellent publication which we print three times a year. Copies are sent to our membership and State and National officers. From this, we have received requests to follow up with detailed reports on programs for the National magazine.

Our "Hazard House" came to National's attention through this medium and they requested that we explain and show this on the closed circuit TV at the AMA convention in San Francisco. We were proud to be chosen one of four State Presidents to appear on this TV for our special project. It required that Mrs. George Schnack, our County President, and her committee work quickly on constructing a new "Hazard House" to take to San Francisco. The previous one had much usage in schools as it was built for the 1965 Health Fair.

The Maui County Auxiliary, with the Woman's Auxiliary to HMA sponsorship, presented a Guest Day program on "Drug Abuse" March 14. This is a community problem on Maui and the citizens are very concerned. Mrs. Sloan prepared packets which were given to each guest and the films *LSD—Insight or Insanity*, *Marihuana*, and *Why Must Flowers Die* were shown. The Maui Police Department set up a display of various drugs, marihuana plants, etc. Dr. Dorothy LaFon, Dr. Robert Bjornson, and the Maui Police Department assisted in the panel discussions. Mrs. Clifford Moran, State President-elect, and Mrs. Louis Rockett, Maui County President, report the interest this program created was outstanding. Excellent public relations was created by the Auxiliary efforts to educate and inform the 65 civic-minded guests.

Our "In Memoriam" Chairman, Mrs. Alexander Haff, states that with the assistance of Mrs. Robert Katsuki, we now have 436 biographies and 248 photographs for "Doctors of Hawaii." Some fascinating tales could be told by Betty Katsuki of the devious methods used to acquire some of the biographies and photographs.

Our Historian, Mrs. Edward Emura, has kept up our

Scrap Book on publicity and our files on the activities of the Auxiliary.

Community Service covers the report of Honolulu County, which is the only one with a Chairman. However, our Chairman, Mrs. George Kimata, states this does not mean the other counties are not doing their share of community service as many work in blood banks, collect for the heart fund, cancer, multiple sclerosis, do hospital volunteer work, and participate in health programs put on by civic organizations such as the YMCA, YWCA, and PTA. Copies of *Today's Health* and *Today's Health Guides* are sent to school libraries. The films *Marihuana* and *Why Must Flowers Die* were added to the Public Health film library by HMA through our suggestion. Hawaii Hazard House is available to schools. "Messages of the Month" are delivered by members of the Auxiliary to doctors' offices. Last October the Auxiliary provided about 100 volunteers to take school children through the Health Fair and staff the information booths. The Auxiliary has been asked to participate in drug abuse programs with the YMCA, Churches, PTA, etc. Project Concern has also asked for our help. The Auxiliary will be joining the YWCA in a program on air pollution and water pollution. We are working with the Department of Education on school health as it relates to sex education. The Heart Association is sending one of our Auxiliary members to a Workshop in Los Angeles to study high-risk factors of heart disease in the hope of educating the public on smoking, alcohol, lack of exercise. AMPAC is sending two of our members to Washington, D.C., to inform us of their plans and to get our membership involved also with our local and national politics. Schools continue to use our "Poisons Go Hawaiian" slides and the Military have made many copies for their permanent use.

Our AMA-ERF Committees have done an outstanding job in fund raising this year. In August our "Bargain Boutique" raised \$2,171.12 for the University of Hawaii Medical School. In addition our Oahu committee raised about \$1,400.00 at its April 5 dinner party at the Kahala Hilton Hotel. Other contributions have been made by the sale of Christmas cards, Sympathy and Appreciation cards, and notepaper. We are proud to advise our President will present the National AMA-ERF check to the University of Hawaii School of Medicine at our Hilo convention of \$4,327.15. This check was \$12.00 in 1966, \$21.19 in 1967, and \$2,393.89 in 1968.

Our Safety Disaster Preparedness Committee chairman, Mrs. Robert Lee, states they are working with the Architectural Barriers to the Handicapped committee and have offered their services to this necessary program. We had excellent coverage for National Poison Prevention Week as the two major newspapers cooperated with several articles. Posters were delivered to drug stores and markets and 250 letters were sent to school principals requesting the teachers to discuss poison prevention to their classes. Our doctors and pharmacists also promoted this by TV, radio interviews, and talks.

We assisted the doctors with Health Careers Day and our Oahu County chairman has prepared an excellent Health Careers Chart.

Our International Health Chairman, Mrs. Philip Lee, has written a most stimulating article for our "Rx for Doctors' Wives." These ladies have really labored to help our fellow man by sending medical supplies, medical equipment, and pharmaceutical samples to faraway places, including Kathmandu, Nepal, the Maris Sisters in Fiji, St. Mary's convent in Tonga, Palay, Western Carolines, the Saigon Hospital in Vietnam, and to Seoul, Korea. It is regrettable that we do not have the space to write Terry's entire article. Happiness indeed is knowing someone cares.

Our National program is "Accent on Youth." We plan to do just this as on June 16, 17, and 18, our Auxiliary will sponsor the GEMS (Good Emergency Mother Substitutes), a baby-sitting project on a large scale with the assistance of the Oahu County. The three two-hour sessions will be from 9-11 and 7-9 in the Mabel Smyth Auditorium. We have the cooperation and as-

sistance of the Fire and Police Departments. Certificates will be awarded to those successfully completing the course. They will be billfold size with emergency numbers printed on the back. We hope to continue this program in different areas on a smaller scale. Our GEMS books of instruction give us a program which graduates baby sitters more knowledgeable in homes and personal safety.

To just mention the Auxiliary projects would be unfair to many of the doctors' wives, who are working closely with many health-related projects throughout the community. We do feel in many cases the Auxiliary has lent them a hand in creating this interest and for this we are grateful.

As you have read in the above report, this has been a busy year. I am most grateful for all the efforts of the Executive Board and the membership for its leadership and participation in making this a productive year for our Auxiliary.

RECOMMENDATION: (1) The Woman's Auxiliary to the AMA has increased our dues another \$2.00 per member which is actually a \$3.00 raise since HMA authorized an allocation of \$5.00 per member nine years ago. An adjustment in our allocation is necessary and we have made a request for an increase to \$10.00 per member, hoping that it will not be necessary to ask for an increase for another nine years. We feel our work in the community and State for the advancement of medicine and public health means being involved and this creates expense. We will leave the amount of the increase of our allotment to the Finance Committee and your House of Delegates. We appreciate your allotment for the continuation of our efforts and will continue to function to the best of our abilities.

MRS. R. VARIAN SLOAN

Woman's Auxiliary President Report

Your Committee next considered the report from the President of the Woman's Auxiliary. A full and complete discussion on the subject was had. Your Committee recommends acceptance of the purpose of the recommendation. However, your Committee reaffirms the Council's action in allowing \$6.00 per member rather than the requested \$10.00. Your Committee recommends approval of the report as amended.

ACTION:

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON INTERNAL AFFAIRS

The Bylaws and Parliamentary Committee Chairman, Dr. Harry Arnold, Jr., has submitted his report.

The Hawaii Academy of Science held its annual fair at Honolulu International Exhibition Hall on Thursday and Friday, April 10 and 11. The Medical Association again gave prizes to some of the participants in Hawaiian Science Fair. However, contrast to the previous years, it was decided to give more prizes rather than the amounts given previously. Dr. Holmes was able to select the exhibits to which prizes were given. The recipient's name and type of exhibits are not available to me at this time.

Six prizes were given \$15.00 per award. No particular names were submitted for the Robins Award to a physician who has contributed considerably for community service.

The Robins Award: A recipient has been selected for this award whose name will be revealed at the time of the annual HMA meeting in Hilo.

No candidate was selected for the Lane Bryant Award. For details of the Arrangements Committee report, kindly refer to Dr. Sloan's committee report.

The program for the Hilo HMA convention has been completed with all speakers and topics selected and confirmed. For details refer to Dr. Wong's report of the Scientific Program Committee.

RECOMMENDATIONS: (1) Continuation of the support of the Hawaiian Science Fair with awards to be given to six recipients at \$15.00 each, judged by a member of the Awards and Special Projects Committee. (2) Continuation of the annual selection of the Robins Award and to continue to pursue for possible recipient to be nominated for the Lane Bryant Award. (3) Plans for future annual convention dates and sites should be pre-selected at the minimum of three to five years in advance with review of the Hawaii Visitors Bureau so that there will be no conflict with any major convention of a national organization. (4) Topics for the annual meeting should be selected and speakers invited at least twelve months before the next convention date so that the most desirable speakers may be booked for our convention and also to provide the most informative scientific program for our membership. (5) Membership on the Scientific Program Committee should also be selected from physicians who are actively participating in the educational program of the various hospitals so that we may utilize the talent of physicians who may be coming to Hawaii at the time of the annual HMA meeting. (6) Each chairman should submit to his committee a list of proposed projects which he hopes to implement during his tenure and the dates when he expects them to be completed.

COOLIDGE S. WAKAI, M.D.

Commission on Internal Affairs

Your Committee next considered the report of the Commission on Internal Affairs. A full and complete discussion on the subject was had. Your Committee recommends approval of the report.

ACTION:

It was voted to delete the second sentence of the third paragraph as this information is in error.

The Chairman moved adoption of this portion of the report. It was adopted.

COMMISSION ON PUBLIC AND INTERPROFESSIONAL RELATIONS

PART I: PUBLIC RELATIONS ACTIVITIES CENTERED AROUND THE THREE MEDIA OF RADIO, TELEVISION, NEWSPAPER, MESSAGE OF MONTH

Communication Media: Of the three media, radio, newspaper, and television, the most controversial area is that of the newspaper media. Throughout the year, there were many occasions in which very favorable newspaper reports were made to improve the image of the physician. Many good reports of physicians were made; there was a matching blemish of the physician's image. Under the able leadership of Dr. Henry Yokoyama, a joint hospital and physician code of cooperation was discussed and generally favored by the committee members. An ad hoc committee was used to study this further in conjunction with Mr. Burkett. It was the feeling also that regardless of how thorough a code of cooperation can be, the ultimate success of mutually satisfying newspaper reporting lies in good relationship between reporters and the Medical Association. It has been the experience of this committee that fewer controversies and hard feelings develop if newspaper articles are first reviewed and discussed by this committee prior to release to the newspaper and further, if the reporter, as well as the person or group interviewed, be present during the review.

Another attempt to generate interest among our physicians to write articles for our local newspaper was attempted and as a start, the members of the News Media Committee would be the authors of these medical reports. A considerable discussion arose concerning bylines following these reports and another attempt was made to convince the Council that this would stimulate interest among the physician population to write medical articles for the local newspaper, but this was rejected. However,

the members went on to write several articles, which at the present time are in the hands of a local newspaper.

The television medium continued to be a very popular and successful source of medical information and orientation for the public. Under the able leadership of Dr. Herbert Uemura and Vice Chairmanship of Drs. Henry Yokoyama and Theodore Tseu, this program has maintained its good rating throughout the fiscal year.

As far as the third medium of radio is concerned, the Japanese Speakers Bureau continued to be a popular source of information throughout the year. The innovation of a Filipino Speakers Bureau under Dr. Cora Manayan was in the making during the past year. As yet, no definite station or time has been established.

Public Relations and Careers Committees: I would like to include the Public Relations Committee under the able and conscientious leadership of Dr. William Goebert here in this Part I report because its activities embrace the three media reported above among other things. His other committee conducted a highly successful Careers Day in February, 1969 and included the neighbor islands medical societies. It was suggested by the chairman of this committee that perhaps besides physicians' careers paramedical careers including laboratory technician, x-ray technician, as well as nursing careers should be considered under one medical careers day.

It was the chairman's philosophy of promoting the physician's good image rather than trying to defend and uphold the image. Dr. Goebert initiated a series of meetings which this committee met with prominent labor union leaders, Mrs. Ah Quon McElrath and Mr. Arthur Rutledge, were carried out and better understanding and exchange of ideas were the motivation of these meetings. The chairman also had intentions of meeting with management in order to reach a common ground of understanding.

During the past year the value of continuing the Message of the Month was challenged several times. An interesting survey by the Woman's Auxiliary was carried out as to the disposition of these messages as they are dropped off in the various doctors offices. The survey showed that some doctors are not even aware of this service, others have been using these messages to scribble notes on, and still others thought perhaps that some of these messages have been sent out with their statements to patients but were not sure. After thorough discussion, it was decided that there were merits as far as this type of communication to the public was concerned and it certainly represented another channel of medical instruction, orientation and information. As a result, this committee under the faithful chairmanship of Dr. William Moore continues to perform.

PART II: ACTIVITIES OF THE OTHER MISCELLANEOUS COMMITTEES UNDER THIS COMMISSION

The following report will be a brief resumé of each of the committees headed under miscellaneous.

Association of Professions Committee: The committee has met twice and is still considered in its organizational stage. At the present time, the merits derived from the activities of this committee have not been appreciated as yet but with future exchange of ideas with other professions, perhaps the assets may be realized. The chairman at the present time has made some endeavor to contact other professions such as the dentists, nurses, etc.

Disaster Committee: On paper and by definition, this committee should be an extremely important committee, but to my knowledge, the committee has not met a single time during the past year. The interstate Civil Defense and Disaster Compact of the Western eight states of the U.S.A. has rejected Hawaii's application. The chairman also stated that during the past year, Maui County had conducted one disaster drill and is encouraging all counties to do likewise on an annual basis.

Nurses Liaison Committee: One of the more contro-

versial problems that this committee has engaged in during the past year was that of clarifying the problem of nurses' dispensing drugs at night. Several sessions were held with regard to this problem. One of the invited guests was Mr. Turk, President of the HPA. Some dialogue was carried out concerning this problem. The problem revolves around the shortage of pharmacists, and their low salary scale are involved in this present controversy. The problem was presented to the Council and it was the Council's opinion that this should be worked out between the respective hospitals and their nursing staffs as well as the pharmacists. Under the able leadership of Dr. H. H. Chun, several current problems were handled very nicely concerning nursing activities such as the use of intracath.

Operation Pacific: This committee was considerably more active during the early 1906's in providing physicians to provide medical care to the people of the various areas in the Pacific, particularly in Samoa. An attempt was made to advise and help the East-West Center as far as obtaining consultants for postgraduate training of the U.S. Trust Territory Medical Officers but this did not materialize and, as a result, the committee has withdrawn as an advisory body. Because of the personal interest of the chairman, Dr. Richert, he has packed both books and medications personally and many times has assumed the cost of disbursing these Care Packages to the South Pacific area outside of the Trust Territory. He would like to have some help in storing these supplies as well as shipping and packaging them.

Quackery Committee: This committee headed by Dr. William Sage met several times during the past year to review questionable activities in the medical profession. It has reviewed a considerable number of problems with excellent disposition and advice to the physicians and public, among these was the phantom surgery in the Philippines. This committee continues to process various complaints and questionable medical practices seen in the State, both mail and practice.

Woman's Auxiliary: This committee continues to carry on nicely throughout the year with its many activities as the advisory body to the Woman's Auxiliary. The Auxiliary was dealt a severe blow when the National Organization increased their dues to \$4.00 per member, thus leaving one dollar per member for their operating budget. The ladies appeared before the Council with a request to increase the HMA allocation to \$10.00 per member. The Council rejected this proposal. It appears that an allocation of approximately \$8.00 per member can be assumed by the HMA in order to match the increase in dues assessed by the National Organization. It is the intention of the Woman's Auxiliary to carry their cause to the House of Delegates in the coming HMA meeting.

Religion and Medicine Committee: This committee is headed by Dr. Francis Soon. He recently returned from a regional workshop held in March, 1969, at Salt Lake City. As yet, the committee has not met to hear his report. This is scheduled for sometime in mid-May.

RECOMMENDATIONS: (1) That the Commission on Public and Interprofessional Relations be definitely divided into two commissions: (a) Part I to be called the Commission on Communications to consist of the News Media, Radio-TV, the Speakers Bureaus, Message of the Month, and Public Relations Committees. (b) Part II to be called the Commission on the Miscellaneous Committees to consist of the Associations of Professions, Disaster, Careers, Nurses Liaison, Operation Pacific, Quackery, Woman's Auxiliary, and Religion and Medicine Committees.

BENJAMIN C. K. TOM, M.D.

Commission on Public and Interprofessional Relations

Your Committee next considered the report of the Commission on Public and Interprofessional Relations. A full and complete discussion on the subject was had. Your Committee recommends approval of the report.

ACTION :

The Chairman moved adoption of this portion of the report. It was adopted.

Resolution No. 1

This resolution relates to commercial advertising of a medical specialty by lay corporations in AMA publications and your committee concurs with its findings.

ACTION :

The Chairman recommended that Resolution No. 1 be adopted. It was voted to adopt the resolution.

RESOLUTION NO. 1 AS ADOPTED

Re: Commercial Advertising of a Medical Specialty by Lay Corporations in AMA Publications.

WHEREAS, The AMA Board of Trustees voted last fall to open all AMA publications to solicitation and commercial advertising of a medical specialty (pathology) by lay corporations; and

WHEREAS, Physicians, by long tradition, are forbidden any activities characterized by self-laudation and solicitation, both of which are essential to commercial advertisement; and

WHEREAS, This Trustee policy encourages the practice of medicine by lay corporations, and promotes solicitation, in violation of all codes of medical ethics, and

WHEREAS, This Trustee policy, adopted without consulting the House of Delegates, will set a precedent for regional, state, and other medical journals, will spread to other fields of medicine and will lower standards of patient care; now therefore, be it

Resolved, By the Hawaii Medical Association, at its 113th Annual Meeting, that this Association

(1) reaffirms medicine's traditional opposition to the practice of medicine by lay corporations, and to solicitation, and to commercial advertising of the practice of medicine; and

(2) requests its delegate to oppose this new AMA Trustee policy vigorously at the AMA convention in New York next July; and

(3) requests this delegate to call on the AMA to reverse this Trustee policy at the July AMA convention in New York City.

Submitted by the
HAWAII SOCIETY OF PATHOLOGISTS

ACTION :

The Chairman moved adoption of the report as a whole as amended. It was adopted.

NOMINATING

The Nominating Committee met and submitted to the Council for its January 22 meeting the following slate of nominees to be presented to the House of Delegates.

President-elect.....John J. Lowrey
Treasurer.....Herbert Y. H. Chinn
AMA Delegates.....George H. Mills
Alternate AMA Delegate.....Theodore T. Tomita
Councilor from Oahu.....Richard D. Moore
Councilor from Oahu.....Grover H. Batten

All nominees have been contacted and have agreed to serve if elected.

THOMAS P. FRISSELL, M.D.

ACTION :

It was moved and seconded that the report of the Nominating Committee be accepted. It was voted to adopt the report.

Nominations were sought for the Nominating Committee. The following were nominated, Thomas P. Frissell, Theodore T. Tomita, Coolidge S. Wakai, William

W. L. Dang, B. A. Richardson, William Iaconetti, Walter S. L. Loo, and Albert C. Johnston. The nominations were closed and the Secretary was asked to cast a unanimous vote.

The President-elect asked for nominations from the floor for President-elect, Treasurer, AMA Delegate, Alternate AMA Delegate, and two Councilors from Oahu. No further nominations were offered. All nominations were closed and the Secretary was asked to cast a unanimous vote.

Having been elected President-elect, Dr. John J. Lowrey asked to resign as Councilor from Oahu. Nominations were asked from the floor for the remainder of his term as Councilor from Oahu. Dr. William W. L. Dang was nominated. The secretary was asked to cast a unanimous ballot.

The results of the election were announced as follows:

President-elect.....	John J. Lowrey
Treasurer.....	Herbert Y. H. Chinn
Councillor, from Honolulu.....	Grover H. Batten Richard D. Moore William W. L. Dang (two years)
AMA Delegate.....	George H. Mills
AMA Alternate Delegate.....	Theodore T. Tomita
Nominating Committee.....	William W. L. Dang Thomas P. Frissell B. Allen Richardson Theodore T. Tomita Coolidge S. Wakai Walter S. L. Loo (Hawaii) William Iaconetti (Maui) Albert C. Johnston (Kauai)

NEW BUSINESS

RESOLUTION

The President-elect asked if there were any new business to come before the House.

ACTION :

It was voted to permit Dr. S. K. Tom to present a new resolution to the House.

The following resolution was presented:

RESOLUTION NO. 18

Re: Commendation of Richard D. Moore.

WHEREAS, Richard D. Moore, M.D., served as delegate to the American Medical Association representing the Hawaii Medical Association for more than ten years; and

WHEREAS, He has been loyal and diligent in his duties as delegate to the AMA, and

WHEREAS, He has given freely of his time for this purpose with no expectation of compensation for the time thus sacrificed; and

WHEREAS, He has given voice to Hawaii Medical Association's problems on the floor of the House of Delegates of the AMA and succeeded in accomplishing many objectives; now therefore be it

Resolved, That this House of Delegates extend its thanks and sincere appreciation for the time and devoted effort given by Richard D. Moore, M.D. on behalf of the Hawaii Medical Association; and be it further

Resolved, That a copy of this resolution be properly inscribed and presented to Dr. Richard D. Moore.

Presented by HONOLULU COUNTY MEDICAL SOCIETY

ACTION :

It was voted to adopt the resolution unanimously and to send to Dr. Richard D. Moore a duly certified copy of the resolution.

WOMAN'S AUXILIARY

The work of the Woman's Auxiliary was noted.

ACTION:

It was voted that the President send a letter of thanks to the Woman's Auxiliary for a job well done.

RESIGNATION

Dr. Sloan read a letter of resignation from Mr. Patrick L. Godfrey, Administrative Assistant, as follows:

For personal reasons I will be leaving the Association no later than July 1, 1969. Under no circumstances will I reconsider my decision.

I feel honored having been "appointed" by the Council to fill the newly created position of Director of Public Affairs. However, I cannot accept the "appointment."

I would like to request that I be paid in advance for the month of June—in addition to any back pay due me. It has been my pleasure serving you.

(S) PATRICK L. GODFREY
Administrative Assistant

ACTION:

Dr. Sloan thanked Mr. Godfrey for the work he has done for the Association and asked the House to join in a round of applause for him.

CHAIRMAN PRO TEM

The work of the Chairman Pro Tem was noted.

ACTION:

It was voted that Dr. George H. Mills be given a standing vote of thanks.

The meeting adjourned at 4:20 P.M.

R. VARIAN SLOAN, M.D.
Secretary

Hawaii Medical Ass'n continued from 480

would be working for ourselves directly or indirectly; we could, as a profession, make provision for the education of interns and residents, etc. . . ."

Dr. Robert Chung was invited to the meeting to elaborate on this matter which had previously been discussed with the Commission on Medical Services.

There was some discussion on the subject and it was felt that since there needs to be more in-depth study on the matter, it should be referred back to the Commission on Medical Services.

ACTION:

It was voted that Dr. Reppun's letter be received and referred to the Commission on Medical Services and to be put together with other pertinent information received, and that the Commission direct the House of Delegates of its recommendations in this area.

BYLAWS & PARLIAMENTARY COMMITTEE REPORT

The report of the Bylaws & Parliamentary Committee was circulated to the Council.

ACTION:

It was voted to refer this report to the House of Delegates for action.

REPORT OF THE SECRETARY

The secretary's report was circulated and reviewed.

The secretary had two recommendations to act upon and they are as follows: (1) That all roster changes reported by the counties for the month of April be accepted. (2) That the registration fee for military physicians be waived for the forthcoming meeting.

The secretary reported that a telephone call was received from the AMA on May 15, to advise that Dr. Dwight Wilbur will arrive in Honolulu from San Francisco on Thursday, May 29, and remain until 1:00 P.M., June 2. The only commitment he has is to address the University of Hawaii School of Medicine on the evening of May 29. He has no other commitments. Mrs. Wilbur will accompany him and they will be staying at the Wai-kiki Grand Hotel. This information is being given to the Council as it may wish to suggest some activities for Dr. Wilbur and make an appropriate allotment. It was noted that Dr. Cutting stated that they, at the University, do not have anything planned for entertainment.

ACTION:

It was voted that the president of the HMA contact Dr. Wilbur to find out his wishes and take appropriate action.

It was voted to extend an invitation to Dr.

Gerald D. Dorman, next AMA President, to attend the HMA's Annual Meeting in 1970.

There was considerable discussion about the number of physicians delinquent in their dues. It was pointed out that delinquent letters have not been sent to these physicians. It was further pointed out that delinquent members must be given 30 days' notice before they are dropped.

ACTION:

It was voted that the secretary be instructed to send a letter to all delinquent members as soon as possible to notify them of their delinquency, and that this letter be sent by certified mail.

REPORT OF THE MEDICAL CARE PLANS COMMITTEE

At the last Council meeting, it was voted that the OCHAMPUS contract be placed on file and that further investigation be conducted to attempt to see if the rate being charged for processing claims is fair and equitable.

The chairman of the Medical Care Plans Committee stated that the matter was discussed with Mr. Albert Yuen of HMSA and an explanation by him was accepted by the committee. The committee, therefore, felt that this discrepancy should not hold up signing of the OCHAMPUS contract.

REPORT OF THE TREASURER

The treasurer's report was circulated, reviewed, and discussed.

ACTION:

It was voted that the material in columns 1-6 be accepted as circulated.

Account #511 (Council Expense): A reduction of \$1,540.00 could be obtained by holding Council meetings during the day, rather than in the evening and not paying for meals or per diem. The per diem elimination is on the basis that the councillors could return to their homes without incurring overnight hotel expenses. In order to arrive at the total shown in the revision, the proposed annual meeting of the Council on another island has been eliminated. Both the original and revised proposals provide for only four meetings.

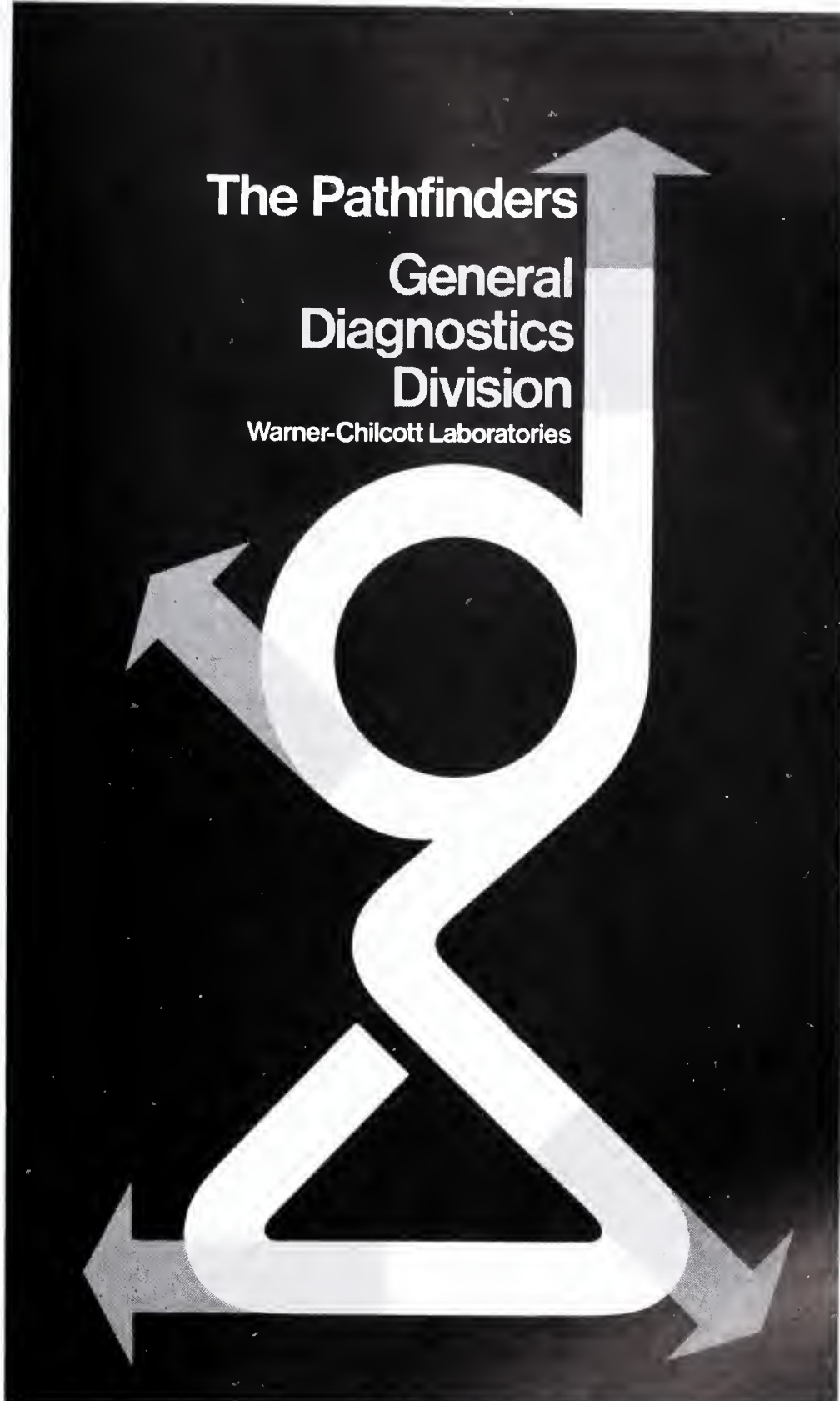
ACTION:

It was voted to accept the change in format of Council meetings and that they be held on Sunday from 10:00 a.m. to 5:00 p.m. with the officers, meeting being held immediately prior to the Council Meeting.

Account #522 (HAMPAC): The \$500 contribution could be eliminated. It was pointed out that the \$500

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The Pathfinders
General
Diagnostics
Division
Warner-Chilcott Laboratories



HAWAII TECHNOLOGISTS' BULLETIN

Official Publication of the Hawaii Society of Medical Technologists

Editor: EDITH G. EKSTEIN, MT(ASCP), U. S. Army Tripler General Hospital

Convention Highlights

Twentieth No Ka Oi! HSMT concluded its twentieth Annual Convention at about dusk on Sunday, May 18, 1969. The four preceding days were educational, entertaining, and packed with so many outstanding and important events that we will try to record here only those which an editorial board of one remembers best and which do not otherwise appear in the record.

About 60 persons registered for the one-day opener at the Princess Kaiulani in Honolulu and about 50 checked in at the Royal Lahaina for the Maui portion of the meeting. Registrants came from Hawaii, Kauai, Molokai, Maui, Oahu, and the mainland U.S.A. We were especially honored by being joined by four registrants from Okinawa. Steve Chinen, who also pronounced the benediction at the banquet, introduced Shinichi Fukuda, Koei Kinjo, Yukimasa Uesato, and Choko Ueda, medical technologists from various hospitals in Okinawa.

Rachel West was chairman of the Convention Committee, which must have performed miracles. Others on the Committee were Mary Nakamura, Stella Yoshida, Leslie Nakashima, Grace Kagawa, Louise Wulff, Debbie Telaak, Terry Erickson, and Pat Taylor. President James Yano, of course, was in on much of the hard work and it was Jim's courage that made neighbor island meeting possible.

Physicians Participate: Following the dinner at the PK on Thursday evening, guest speaker E. Ross Jenney, M.D., addressed the assemblage on "The Population Explosion." On Friday at Lahaina Robert Worth, M.D., was the after-dinner speaker and discussed "Our Health System and the Coming Impact of Automatic Screening Examinations." Both Dr. Jenney and Dr. Worth are affiliated with the University of Hawaii and both were asked many questions after their thought-provoking talks.

Floor Show Also No Kai Oi: Entertainment at the banquet on Saturday was an original program which was so good that we feel sorry for everyone who missed it. Louise Wulff wrote the skit. Pat Taylor rewrote the lyrics and directed the entire program. The performers were as follows: Dianne Campbell, Helena Chun, Claudia Minei, and Ethel Nakagawa of the med techs; interns Carolyn Inoshita, Wilma Loo, Sue Pang, Cheryl Sugiyama, and Carol Torikawa; UH senior Linda Harloe and UH junior Faith Kawahara.

The theme of the program was a rainbow, so much a part of Hawaii, particularly Manoa where each of the participants is or was a student at the University of Hawaii.

The opening song on the program was "Look to the Rainbow" with narration by Dianne Campbell and a solo by Carol Torikawa, followed by "Wish Me A Rainbow" with new words by Pat Taylor to set the scene on Maui. "The Hasegawa General Store" reinforced the Maui mood, but this was shattered along with the quiet of the evening by the laughter which greeted the dramatic production of the evening, a skit which depicted the new Med Tech 4+1 program now in operation at UH. Following the skit, the group sang "Those Were The Days" to reflect the sentiments which are shared by those in the new course and those who finished in the older curriculum.

Following intermission, the talented group sang seven more songs and the entire audience joined in the eighth, "Lahainaluna." Interspersed among the songs was an Okinawan dance by Claudia Minei and a hula by Faith Kawahara.

Congratulations

HSMT has the rare privilege of offering congratulations to five persons who have in the two weeks prior to this writing won noteworthy honors for themselves and in so doing brought honor to all of Hawaii's Medical Technologists.

Elaine (Tiny) Chang received the Warner-Chilcott Award of \$100 for being selected Outstanding Medical Technologist of the year in Hawaii. The recipient of this award, presented at the banquet in Lahaina, is selected by those most-difficult-of-all judges: fellow med techs. Tiny is a graduate of UH and the Tripler School of Medical Technology. She has been employed by the Hawaii State Department of Agriculture since 1954, is a past President of HSMT, and takes part in more volunteer activities in the community than we have space for.

Also introduced at the banquet were the recipients of this year's award for the Outstanding Intern in Hawaii's ASCP Approved Schools. The award is made by the Hawaii Pathologists Association and the Pathologists also select the recipients. Shirley Hew, who interned at St. Francis Hospital, and Carol Torikawa, who interned at Kaiser Hospital, shared the award.

Besides winning the Outstanding Intern Award, Miss Torikawa was graduated with honors for her work on a paper entitled *Lymphocyte Typing*.



Miss Linda Harloe, recipient of the Real Dean Award.

Miss Linda Harloe, who received the Pathology Departmental Award and the Real Dean Award (the highest honor given a graduating senior at UH), was also graduated with high honors. Her paper was entitled *The Immunological Determination of Hemopexin in Normal and Hemolyzed Human Serum*. Linda, a 4 + 1 graduate, will intern at St. John's Hospital in Santa Monica. She promises to return to Hawaii and we will hold her to that promise!

Miss Caroline Inoshita, who interned at the Queen's Medical Center, was graduated with high honors. Her paper was entitled, *The Quick One-Stage Prothrombin Time Test and an Evaluation of Two Thromboplastin Reagents*.

Not all that deserve mention were accorded academic honors. We would like to salute "Two Who Returned!" Miss Dianne Campbell, a registered Medical Technologist employed at Kuakini Hospital, has been taking classes for the last two years to complete work for her degree. She was registered with ASCP following internship at Port Huron Hospital in Michigan. Dianne not only worked full time while going to school, but found time to be active in the Student Med Tech Club.

Mrs. Mary Turley, who interned at Kaiser Hospital, came back to school after her family grew up enough to allow her time for study. At one time, Mary had dreams of becoming an architect. But that was before marriage and three fine boys, Mark, Jr., David, and Chris. When she returned to school, her interest had turned to the sciences and, luckily for us, Med Tech was her choice. We were sorry not to see her at Commencement last June 8. She attended instead David's graduation from Kalani High School, a proud mother's proper choice!

Mary and Dianne, we salute you and hope your fine example will inspire others to come back to school.

HSMT Elects New Officers

The annual meeting of HSMT was held on the evening of May 15, 1969. The following were elected to office for the year beginning July 1, 1969:

PRESIDENT-ELECT: Mary Connor, Hilo Hospital

RECORDING SECRETARY: Mary Nuha, Piikoi Medical Laboratory
CORRESPONDING SECRETARY: Clara Nagano, State Department of Agriculture
TREASURER: Ronald Miyakawa, Waimano Home
BOARD OF DIRECTOR: Dorothy Matsuo, U of H graduate student.

Betty Hughes, State Hospital, becomes President after serving as President-elect during the past year. In so doing she becomes the first person to serve twice as HSMT's presiding officer. The gavel which Jim Yano handed to Betty to symbolize the change of authority is a beautiful monkey-pod poi pounder which Roy Hughes carved during his wife's first term as President.

Jim Yano as Past President remains on the Board of Directors for another year and Pat Taylor, who was elected last year, also has another year to go before her term is completed.

Recognition for the Exhibitors

This Bulletin has no commercial ties and generally does everything it can to avoid what might be construed as endorsements. However, because our Twentieth Convention's success was due in so large a measure to our commercial exhibitors, we want to express HSMT's gratitude here. The exhibitors had to set up in Honolulu, then pack everything and set up again the following day in Lahaina.

These same people presented workshops in both Honolulu and Lahaina, they answered questions, provided handouts to all who desired them, and generally made themselves virtually indispensable. For the privilege of doing so much for us, each one paid a fee to the Convention fund.

Sincere thanks, therefore, go to the following:

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Mahalo to Dr. and Mrs. Moran

Dr. Clifford Moran, Pathologist at Maui Memorial Hospital, and Mrs. Moran hosted a picnic on Sunday, May 18, for everyone who attended the Lahaina meeting. A large group turned out and enjoyed the Moran's hospitality at their lovely home on the beach at Kihei. The afternoon also provided an opportunity for visiting med techs to become better acquainted with their Maui colleagues. The picnic was a delightful wind-up for a first-rate convention. Mahalo, Dr. and Mrs. Moran! ■

contribution is used for political newsletters and education programs, and includes stationery and supplies. Other monies received from individuals go towards candidate support. At the present time there is a balance of \$250 in the political education account.

ACTION:

It was voted that this fund be established at \$200.00.

Account #541 (President's Contingency Fund): The \$500 could be eliminated. It was brought to the attention of the Council that in the past five years, the following amounts have been spent from the President's Contingency Fund: 1968, \$80.10; 1967, \$217.59; 1966, \$262.09; 1965, \$0; and 1965, \$24.13.

ACTION:

It was voted that the President's Contingency Fund be retained and that the figure be set at \$500.

Account #534 (Meeting Expense): By eliminating the lunches and breakfasts served at Mabel Smyth and the proposed cocktail party (\$5.25 per head is current figure being quoted by the Hawaiian Village) for Dr. and Mrs. Dorman, a reduction of \$5,000 could be effected. The \$300 listed would amply cover the cost of serving coffee and tea. Attendance at most meetings has been excellent. The meetings at Mabel Smyth are attended by people from the community—legislators, labor leaders, PTA officials, DOE representatives, etc.—who are involved in medically related projects. The increase in cost in this account is due to increased attendance and an increase in the number of meetings which are being scheduled.

ACTION:

It was voted that account #534 be retained and that the figure of \$4,000 be set.

Account #562 (Inter-Island Travel): This account could be reduced by \$500 if the interisland travel is confined to one visit a year to each county society by the HMA president. For the past few years the president-elect has been accompanying the president on these trips.

It was felt by some members of the Council that it is important that the president-elect accompany the president to the neighbor islands. It was reported by two neighbor island councillors that these visits have been most beneficial to their societies.

ACTION:

It was voted that account #562 be maintained at \$700.

Account #562 (Mainland Travel): This account could be reduced by \$5,340 by adopting the following policy: (1) All travel on the basis of K class (lowest fare, no meals). (2) No authorization for the president-elect to attend either meeting. (3) Reduction of the per diem rate from \$50 to \$35 for the delegate and the president and to \$25 for all others. Only two people to attend the clin-

ical session. It is the policy for the executive secretary to attend the AMA meetings using K class transportation and being reimbursed for actual expenses, approximately \$25 a day.

ACTION:

It was voted that four members from HMA should go to the AMA Convention in New York, two to the Clinical Session in Denver, and five representatives to the AMA Convention in Chicago travelling first class, and that the per diem be reduced to \$35.00 on the basis of five days in New York, four days in Denver, and five days in Chicago.

Woman's Auxiliary: At the last Council meeting, the Council voted not to increase the contribution to the Woman's Auxiliary. After some discussion, the Council reconsidered this matter.

ACTION:

It was voted to increase the Woman's Auxiliary contribution to \$4,200.

Public Affairs Department: The Treasurer pointed out that there are no amounts inserted either for the current or coming fiscal year for the Public Affairs Department, the establishment of which was approved at the April 23 meeting.

ACTION:

It was voted to retain the Public Affairs Department and that the budget be increased to include \$10,000 for this position.

The entire budget was considered.

ACTION:

It was voted that the budget be accepted as amended and presented to the House of Delegates.

EXECUTIVE SESSION

The Council went into executive session and the staff members present were excused.

As a result of its deliberations, the following actions were taken:

ACTION:

It was voted to engage a management consultant to look over the operation of the Hawaii Medical Association office and staff and to make recommendations regarding administrative functions and efficiency.

It was voted to have the officers of the Association choose the consultant and make determination of the fee to be paid.

It was voted that the establishment of the Public Affairs Department not be implemented until after receipt of the consultant's report.

ADJOURNMENT

The meeting adjourned at 12:50 A.M.

R. VARIAN SLOAN, M.D., *Secretary*

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trol of hemorrhage, and in surgical technique would be valuable additions to the manual. The authors could expand their chapters on organ transplantations and immunology, chemotherapy of cancer, and radiation biology, since they will become more important in the future.

The manual is masterfully written. Its greatest benefit and use will be to the student clerk, intern, and resident in training. The references at the end of the manual should include historical as well as more classic and representative articles and books, so that the student can use it as a source.

The manual will be a welcome addition to students beginning in surgery and is recommended for all who deal with surgical patients.

GLENN KOKAME, M.D.

Zinsser Microbiology, 14th Ed.

By David T. Smith, M.D., and eighteen contributors, 1,281 pp., \$17.75, Appleton-Century-Crofts, 1968.

THIS IS A NEW edition of one of the classical textbooks in this field. Its title in the first edition was "Textbook of Bacteriology." Expansion of the subject matter to include the broader scope of microbiology is certainly useful to the intended audience, medical students and their teachers. The sections of bacteriology and virology include the most recent revisions of taxonomic classifications. As might have been expected from these authors, the section of mycology is very well done. The section on immunology is considerably expanded in comparison to previous editions and now includes a section on tissue transplantation.

If there is a fault to find, it is in the section devoted to parasitology. This scarcely touches the more recent developments in the tissue reactions and immunology of helminthic disease, is indifferently illustrated, and is too brief even for its intended audience. It is hoped that future editions will either eliminate or improve this section. In all other respects the text certainly fills a real need and its acquisition is recommended.

G. N. STIMMERMANN, M.D.

★Principles of Nuclear Medicine

Edited by Henry N. Wagner, Jr., M.D., 896 pp., \$27.50, W. B. Saunders Company 1968.


NO TEXTBOOK can quite keep up with the pace of change in nuclear medicine. This one, however, has done a remarkable thing by providing a solid background while sensing out and previewing instruments and isotopes which will be used in Hawaii for the next several years. Specifically, it reviews rectilinear scanners in common use here and compares them to the gamma camera, of which there are now three in Hawaii. While reviewing the standard, proven radiopharmaceuticals and their standard, proven uses, it moves out into the new ones which are just becoming available to practitioners. Most notable are ^{99m}Te and ^{113m}In, both of which have short half-lives and desirable scanning characteristics. The combination of rapid imaging devices and very short half-life materials will greatly expand the practice of nuclear medicine by providing improved pictures in shorter time with less body irradiation.

Much of the quality of this text derives from its remarkable editor, who is one of the foremost radio-pharmaceutical experts as well as a feet-on-the-ground instrumentalist and an imaginative internist. His short

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chapter on The Diagnostic Process should be read by every physician who has even a casual eye cocked in the direction of computer diagnosis.

This is the third recent text on nuclear medicine, the other two being "Nuclear Medicine" edited by Blahd, (McGraw-Hill, 1965—new edition to appear shortly), and "Radioactive Nuclides in Medicine and Biology—Medicine" by Silver (Lea & Febiger, 1968). Each is somewhat limited, each is strong in special ways. Anyone working directly in the field of nuclear medicine should have all three at his fingertips.

ROBERT A. NORDYKE, M.D.

X-ray Diagnosis of Congenital Cardiac Disease

By Larry P. Elliott, M.D., and Gerold L. Schiebler, M.D., 240 pp., Charles Thomas, 1968.

THIS BOOK DOES precisely what it sets out to do; i.e., it presents a concise (240 pp. of large print) and easily understood syllabus of 11 basic congenital cardiac lesions for the physician *initially* seeking an acquaintance with the commonest congenital defects.

It is not an atlas of roentgenograms but a logical presentation of x-rays correlated with an easy-to-follow text describing the physiology, and auscultatory and EKG findings, in these lesions.

The introductory chapter is excellent and the book is especially recommended for house officers and the beginner in cardiology who will derive a great deal of knowledge from approximately 2½ hours reading time.

FRANCES F. NAKAMURA, M.D.

Proprioceptive Neuromuscular Facilitation, 2d Ed.

By Margaret Knott, B.S., and Dorothy E. Voss, B.Ed., 225 pp., \$9.50, Hoeber Medical Division, Harper & Row, Publishers, 1968.

THIS SECOND EDITION has the purpose of inciting motor learning, a technique which was developed at the Kabat-Kaiser Institute. It is well illustrated and easy to read, although technically complicated.

The approach to this facilitation technique enlists the *less* involved parts to elicit reflex activity of involved muscle groups and components of motion, which is a reversal of the usual approach.

Proprioceptive Neuromuscular Facilitation technique involves pressure, stretch, resistance, and rhythmic stabilization. Applying the principles of facilitation on the one-to-one patient-therapist relationship required would be difficult in most institutions with heavy case loads and limited staff.

ELISABETH K. ANDERSON, M.D.
THEODORE T. TAGAWA, RPT

Handbook of Pediatric Medical Emergencies, 4th Ed.

By Charles Varga, M.D., and contributors, 694 pp., \$19.75, The C. V. Mosby Company, 1968.

THIS IS A valuable guide for all physicians who treat children and for those who are responsible for the training of house staff members and nurses in emergency techniques.

Most of the chapters have been rewritten. The outline style gives the material accessibility. Also, it is easy to digest quickly, an asset during any emergency situation.

The emergency room staff might well follow the procedures outlined in checking for readiness to administer quality care without delay. This also applies to those who treat children in the wards, nurseries, and offices.

RICHARD K. B. HO, M.D.

Selected Papers on Direct Psychoanalysis, Vol. II

By John N. Rosen, M.D., 172 pp., \$6.50, Grune & Stratton, 1968.

THIS IS AN INTERESTING book for the psychiatrists who deal with severely ill patients since Dr. Rosen is at once a highly controversial, but important contributor to both the theory and practice of psychiatric treatment.

KWONG YEN LUM, M.D.

★Atlas of Precautionary Measures in General Surgery

By Ivan D. Baronofsky, M.D., Ph.D., 281 pp., \$23.50, The C. V. Mosby Company, 1968.

THIS INTERESTING and useful atlas aims at preventing complications in surgery. It contains many operative "pearls" derived from a rich personal experience. It adds a final polish to operative technique by calling attention to many fine details that usually are a hallmark of a good surgeon. This volume should have wide interest because it covers the more common operations performed in general surgery in a very concise and clear manner. The illustrations are superb and vivid.

RICHARD T. MAMIYA, M.D.

Social Psychiatry

Edited by Joseph Zubin, Ph.D., and Fritz A. Freyhan, M.D., 382 pp., \$14.50, Grune & Stratton, 1968.

THIS COLLECTION of papers, which is the proceedings of the fifty-seventh annual meeting of the American Psychopathological Association held in New York City, February, 1967, is timely in view of the burgeoning growth of community mental health centers throughout the nation as well as here in Hawaii. Of special interest is a long and thoughtful paper by Bernard & Crandell on "Evidence for Various Hypotheses of Social Psychiatry."

KWONG YEN LUM, M.D.

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A Manual of Electroneuromyography

By Hyman L. Cohen, M.D., and Joel Brumlik, M.D., M.S., Ph.D., 178 pp., \$10.50, Hoeber Medical Division, Harper & Row, 1968.

THIS IS A PRACTICAL manual suitable for the beginner in electromyography and electrodiagnosis. Strictly a "primer" of practical EMG. It would be a disappointment to anyone well versed in the technique.

The latter half of the book consists of "illustrative case reports" and shows a lot of forms which appear to be extraneous. This latter half of the book could be cut down to a great degree. The addition of more practical suggestions applicable to the clinical electromyographer would be helpful.

The term "electroneuromyography" may be unfamiliar to many people. Most people still refer to these studies as EMG, although strictly speaking, most electromyographers include other electrodiagnostic methods, such as electrical stimulation of nerves to measure latencies and conduction velocities. However, no good all-inclusive term is yet accepted and most people usually assume that the term EMG will now include all these other ancillary electrodiagnostic studies that are useful in the study of patients with neuromuscular problems.

MICHAEL M. OKIHIRO, M.D.

★Handbook of Psychiatric Consultation

By John J. Schwab, M.D., with a forward by Henry W. Brosin, M.D., 318 pp., \$8.50, Appleton-Century-Crofts, 1968.

ALTHOUGH THIS BOOK was written primarily for psychiatric residents and medical students, many psychiatrists as well as other physicians, especially those engaged in clinical teaching, should find the volume well worth reading. Detailed descriptions of consultation techniques are described in various settings, such as the general hospital, the community, and private offices. Dr. Schwab subscribes to a holistic approach to the patient: he emphasizes the need to recognize in consultation not only the needs of the patient and his environment, but also the needs of the consultee, and his relationship to the patient. There are brief chapters on the various psychiatric syndromes and symptoms and how these relate to some of the more difficult differential diagnoses that have to be made.

Dr. Schwab is the principal author, and, in addition, there is a lucid and well-written chapter by Dr. Paul Adams on "Techniques for Pediatric Consultation." The book closes with a section describing the teaching program in psychiatric consultation at the author's own medical school at the University of Florida. This should be of great help to those developing their own training programs in this area. The bibliography is comprehensive.

KWONG YEN LUM, M.D.

★Textbook of Radiologic Technology, 4th Ed.

By Charles A. Jacobi, B.S.R.T. (A.R.R.T.), and Don Q. Paris, R.T. (A.A.R.T.), 480 pp., \$12.75, The C. V. Mosby Company, 1968.

PRIMARILY this is a text for the student x-ray technician. It covers the wide field of knowledge needed in x-ray technology. This includes chapters on the fundamentals of radiography and x-ray physics and proceeds on through radiographic principles and film processing. This is followed by chapters on the various areas of the body and systems. Each of these include not only the radiographic technique and positioning but also sections on anatomy.

This makes a satisfactory text for the student technician and a good reference book for the practicing x-ray technician. It does not compete with the "atlas" type of x-ray technique books, as the various views and positions are a good deal more limited. Nevertheless, the material is surprisingly complete.

GEORGE W. HENRY, M.D.

★Recent Advances in Pediatric Clinical Pathology

By C. Charlton Mabry, M.D., M.S., (Ped.) F.A.A.P., Irene E. Roeckel, M.D., F.A.S.C.P., Robert E. Gevedon, B.S., M.T., (ASCP), A.A.C.C., John A. Koepke, M.D., M.S. (Path.), F.C.A.P., 247 pp., \$14.50, Grune & Stratton, 1968.

THIS CONCISE, well-organized manual of pediatric biochemistry procedures is highly recommended to all workers in this field. It presents an interesting concept of performing routine chemical procedures for patients of all ages on micro amounts of blood on automated analyzers. Manual methods are also presented for each of the procedures.

Other sections of the book include those on endocrine diseases and inborn errors of metabolism, and also a short section on cytogenetic procedures.

HERBERT S. UEMURA, M.D.

Infectious Diseases of Children, 4th Ed.

By Saul Krugman, M.D., and Robert Ward, M.D., 428 pp., \$16.50, The C. V. Mosby Company, 1968.

AS THE AUTHORS SAY in their introduction, "the contemporary explosion of knowledge detonated by an unprecedented number of investigations including those of the biologic sciences demands frequent *revision* [italics mine] of textbooks such as this one." Considering the authors' stature in the profession and the importance of the subject material, one might have expected something more than this fourth edition presents. A comparison of the listed references in this edition with the last does not seem to reflect any great explosion of knowledge in the intervening time. The only new chapter, "Sepsis in the

continued page 548



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The next time
you treat a patient
with urinary tract infection,
remember

THE SPECTRE OF RECURRENCE



Up to 80% recurrence of bacteriuria: a need for long-term suppressive therapy?

You can readily clear the urine of bacteria and control the acute phase of urinary infection with specific antibacterial therapy. But is that enough? Continuing reports on the high rates of recurrence (80% in some cases¹⁻³) suggest that it is not.

A growing number of clinicians now feel that immediately after the control of the acute phase in patients with a history of recurrence, long-term suppression of bacteriuria should be considered and may provide a greater measure of success.

Many clinicians have found Mandelamine helpful in preventing recurrences and fulfilling the need of long-term suppressive therapy.

Mandelamine reduced recurrences in adult males³

The interim results of a continuing study in seven U. S. Public Health Service hospitals demonstrate that long-term treatment with urine sterilizing agents can control recurrence of bacteriuria in adult males. However, long-term therapy was only effective if initial sterilization of the urine was achieved with broad-spectrum antibiotic therapy.

In this study such antibiotic therapy eradicated bacteriuria in 88 percent of 122 patients. Then each of these 107 patients was placed randomly in one of four groups. After 13 months the recurrence of bacteriuria rates was 86% for the placebo group, 46% for the nitrofurantoin group, 43% for the sulfamethizole group and 22% for the methenamine mandelate (Mandelamine) group*.

*In this group, the greater interim use of antibiotics for incidental infections, and minor variations in distribution of patients as to adverse host factors, may have contributed to the better response.

Mandelamine has also been shown to reduce recurrences in children⁴ and to be of value in the treatment of bacteriuria associated with chronic infections.⁵

Mandelamine— a logical choice

There has been increasing interest in the use of long-term suppressive therapy, although the benefits are not yet fully established. In each case, the physician must decide, based on the history of recurrences, whether he wishes to institute long-term bacteriuria control. When the decision is made to utilize such therapy, Mandelamine is a logical choice.

When utilized immediately after antibiotic therapy, Mandelamine, in conjunction with a urinary acidifier (if necessary) is a useful agent in preventing recurrences of bacteriuria. Through its local action in the urine, Mandelamine exerts its antibacterial effect against a wide range of gram-negative and gram-positive pathogens. Unlike sulfonamides and antibiotics, it does not foster development of bacterial resistance. And Mandelamine offers the safety margin and economy so important in long-term use.

Q.i.d. dosage

Since the methenamine class of drugs is rapidly excreted, a *q.i.d.* dosage of Mandelamine is recommended for a more continuous level of the antibacterial agent in the urine.

1. *Mod. Med.*, 34:109 (April 11) 1966. 2. *The Kidney*, ed. 3, Boston, Little, Brown & Co., 1967, pp. 286-291. 3. *Ann. Int. Med.* 69:655 (Oct.) 1968. 4. *Am. J. Dis. Child.* 105:560 (June) 1963. 5. *Hosp. Med.* 4:73 (May) 1968.

Description: Mandelamine (methenamine mandelate), a urinary antibacterial agent, is the chemical combination of mandelic acid with methenamine.

Indications: Mandelamine (methenamine mandelate) is indicated for the suppression or elimination of bacteriuria associated with pyelonephritis, cystitis and other chronic urinary tract infections; also for infected residual urine sometimes accompanying neurologic diseases. When used as recommended, Mandelamine (methenamine mandelate) is particularly suitable for long-term therapy because of its safety and because resistance to the nonspecific bactericidal action of formaldehyde does not develop. Pathogens resistant to other antibacterial agents may respond to Mandelamine (methenamine mandelate) because of the nonspecific bactericidal effect of formaldehyde formed in an acid urine.

Contraindication: Contraindicated in renal insufficiency.

Precautions: Dysuria may occur (usually at higher than recommended dosage). This can be controlled by reducing the dosage and/or acidification.

When urine acidification is contraindicated or unattainable (as with some urea-splitting bacteria), the drug is not recommended.

Adverse Reactions: An occasional patient may experience gastrointestinal disturbance or a generalized skin rash.

Dosage and Management: The average adult dose is 4 grams daily given as 1.0 Gm. after each meal and at bedtime. Children 6 to 12 should receive half the adult dose and children 5 years of age or under should receive 250 mg. per 30 lb. body weight, four times daily. Since an acid urine is essential for antibacterial activity with maximum efficacy occurring at pH 5.5 or below, restriction of alkalinizing foods and medication is thus desirable. If testing of urine pH reveals the need, supplemental acidification should be given.

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Book Reviews continued from 543

Newborn." is excellent, with good references, and suggestive of what a true revision of the book might have been.

It is disappointing to see so many missed opportunities and, sometimes, confusion. Thus, in a section on enteroviruses, opposite the page discussing herpangina, are some nice color pictures of herpes simplex lesions. With the great volume of clinical material available to both authors, they could have made a great visual presentation of the comparison of the common exanthems and enanthems seen in practice. There is a beautiful color photograph of diphtheritic tonsillitis but none of the membranous tonsillitis of infectious mononucleosis.

Like the reviewer of the third edition, Dr. Joseph Oren, I believe such infectious diseases as tuberculosis, syphilis, and certain rickettsial and mycotic diseases should have been included. A few unfortunate treatments are recommended, for instance, digitalization without regard to the age of the child.

In summary, this is a good and useful textbook, but not so good as I would have expected and certainly no great improvement over the last edition.

JOHN R. STEPHENSON, M.D.

★Radioactive Nuclides in Medicine and Biology, 3rd Ed.

By Solomon Silver, M.D., 539 pp., \$12.50, Lea & Febiger, 1968.

THIS IS A GOOD book. It covers the clinical uses of radioisotopes with surprising depth and clarity. Limitations lie mainly in the fact that it is increasingly difficult for a single author to collate the rapidly expanding field it encompasses. The book therefore "may well represent the last attempt at a single-authored text" in nuclear medicine.

While one author can provide balance, he is also prone to emphasize and detail his own areas of special expertise and interest. Dr. Silver's bias is clearly towards the thyroid, since nearly half the book is concerned with physiology, function testing, scanning, and treatment of this gland. It is probably the best available summary of the use of radioisotopes in thyroid diagnosis and treatment, including both hyperthyroidism and thyroid cancer.

However, in the clinical practice of nuclear medicine, an increasing proportion of the work lies in nonthyroidal areas, especially in the brain, lungs, liver, and kidneys. This trend is being reinforced by the availability of short-half-life isotopes, especially ^{99m}Tc and ^{113m}In , and of rapid-imaging devices such as the gamma camera. The combination allows radioisotope distribution pictures to be taken in a few seconds, thereby allowing their use for dynamic blood flow studies and for simplified approaches to screening for disease rather than waiting for obvious clinical manifestations. While there is less thorough coverage of these areas, the discussions are adequate and the references are unusually good.

ROBERT A. NORDYKE, M.D.

Evil in Man: The Anatomy of Hate and Violence

By Gustav Bychowski, M.D., 98 pp., \$4.75, Grune & Stratton, 1968.

EVIL IS DEFINED primarily in a social context, i.e., "wilful and deliberate harm inflicted by one human being on another." In this spirit, man's various types of hostility to his own kind are briefly traced throughout history, ending with excellent capsule descriptions of present-day violence as epitomized by the Watts riot and Hell's Angels. Although psychoanalytic metapsychological formulations make up a large part of the author's explanations regarding the genesis and development of hostile de-

continued page 552

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Book Reviews continued from 548

structiveness in man, some emphasis is given to recent ethological studies by Portmann, Lorenz, and Ardey. This book is essentially a long essay and probably is best suited for readers already familiar with some of the psychiatric literature.

KWONG YEN LUM, M.D.

Progress in Atomic Medicine, Vol. II

Edited by John H. Lawrence, M.D., 274 pp., \$12.75, Grune & Stratton, 1968.

THIS SECOND VOLUME includes some recent advances in nuclear medicine written by authoritative sources. The first chapter concerning hormonal studies using radio-immunoassays is written by our own Fred Greenwood, now at the University of Hawaii Medical School. It is an excellent dissertation on all the peptide hormones currently being investigated. The chapter on pulmonary-cardiac function studies with short-lived isotopes is also of interest. Bone marrow distribution studies done with positron scanning is also discussed. The comprehensive chapter on red cell production and destruction is very adequate. The chapter on the Status of Therapy with Radioisotopes and Clinical Scanning is of value to clinicians using radioisotopes. The Kinetics of Metabolic Processes is rather technical and would be of interest for physiologists. The last chapter deals with interesting aspects of space medicine as related to radiation. In general these selected subjects are comprehensively discussed and are of value for those clinicians with these specific interests.

WINFRED Y. LEE, M.D.

Also Received

The Evolution of Preventive Medicine in the United States Army, 1607-1939

By Stanhope Bayne-Jones, M.D., prepared and published under the direction of Lieutenant General Leonard D. Heaton, The Surgeon General, United States Army. Editor in Chief Colonel Robert S. Anderson, MC, USA, 255 pp., \$2.50, U.S. Government Printing Office, 1968.

A HISTORICAL resumé of preventive medicine in the military medical service.

Police Medical Dictionary

By J. E. Schmidt, Ph.B.S., M.D., Litt.D., 246 pp., \$14.50, Charles C. Thomas, 1968.

A FAIRLY COMPREHENSIVE medical dictionary which may be helpful to paramedical personnel as well as the police.

Electrocardiographic Notebook, 3rd Ed.

By M. Irené Ferrer, M.D., 141 pp., \$3.45, Hoeber Medical Division, Harper & Row, 1968.

THIS PAPERBACK notebook is recommended for the house-staff and physicians desiring a quick and ready reference source of basic electrocardiography.

Oxygen Transport in Blood and Tissue

Edited by D. W. Lubbers, U.C. Luft, G. Thews, E. Witzleg, 264 pp., \$14.75, Georg Thieme Verlag, Stuttgart, Distributor in U.S.A. International Medical Book Corp., 1968.

A RATHER TECHNICAL symposium which is of value for those interested in this aspect of physiology.

Fundamentals of Biostatistics

By Stanley Schor, Ph.D., 312 pp., \$8.95, G. P. Putnam's Sons, 1968.

THE IMPORTANCE of biometries cannot be overemphasized. This text on basic statistics for the medical investigator is highly recommended for all clinicians who must use these methods for investigation as well as for interpretation of investigative results.

Physical Standards in World War II

Editor in Chief Colonel Robert S. Anderson, MC, USA, 356 pp., \$3.00, Office of the Surgeon General, U.S. Government Printing Office, 1967.

THIS IS AN EXCELLENT reference source for those interested in the physical standards required for our military forces.

How to Pass Entrance Examinations for Practical Nursing Schools

Edited by Eileen-Mary E. Ryan, 249 pp., \$3.95, Cowles Education Corporation, Look Bldg., 488 Madison Avenue, New York, N.Y., 10022.


How to Pass Entrance Examinations for Registered and Graduate Nursing Schools

Edited by Eileen-Mary E. Ryan, 399 pp., \$3.95, Cowles Education Corporation, Look Bldg., 488 Madison Avenue, New York, N.Y., 10022.

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continued page 554

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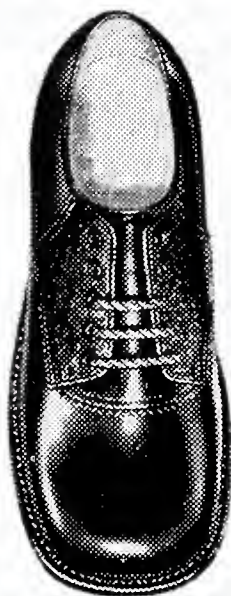
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Book Reviews continued from 553

Dialogue in Medicine and Theology

Edited by Dale White, 176 pp., \$1.95, Abingdon Press, 1968.

THIS PAPERBACK is a synopsis of the Convocation on Medicine and Theology held at Mayo Clinic in April, 1967. The emphasis is on the communion of the ministry of healing and faith aiding the affliction of the body, mind, and spirit.

Comprehensive Review for the Radiologic Technologist

By Matthew Stevens, R.T., and Robert I. Phillips, R.T., FASRT, 181 pp., \$7.25, The C. V. Mosby Company, 1968.

THIS CLEARLY WRITTEN and concise text should be of great value as a reference text for the radiologic technician during his training and perhaps as a "refresher." ■

Notes and News continued from 485

cardiologist with the Queen's heart team offered, "We use extracorporeal circulation at 15° centigrade." "What is the limit?" Cas repeated. Unoji was curt: "We never went the limit."

Ed Chesne again received the award for "The Staff Member Who Contributed the Most to the Training Program for 1968-69."

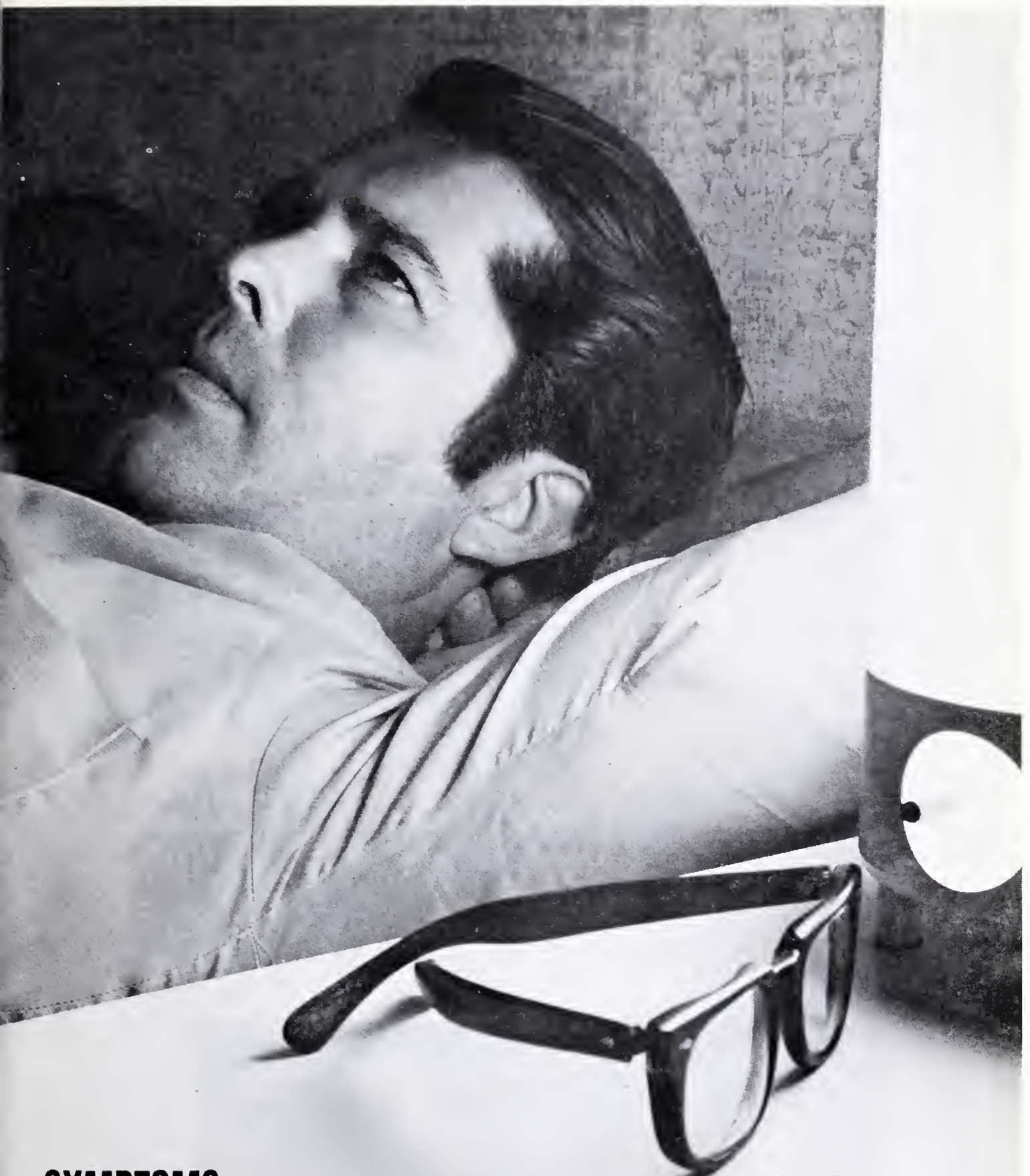
The medical death conference was on a 65-year-old man with cor pulmonale. Max Botticelli started the panel discussion with the rueful comment, "This morning I am in the unenviable position of being a straight man for Phil Jones." Our perennial humorist, Phil Jones, commented, "I remember this man well. He was beyond help. If he could have been helped, we would have saved him." Philip Foti belabored the point, "We must draw blood gas before using the respirator and repeat blood gas determinations at intervals." Phil quipped, "There are clinicians who can do without blood gas determinations, but unfortunately they are not in this country."

Dick Blaisdell lectured on anemias at a Friday morning conference, but carefully distributed a prepared lecture outline before starting. The drawling medical philosopher, who admits to a tendency to digress, confided that he had had a critique about his lectures with his 2d year medical students. The students had advised him, "First, tell us what you're gonna say. Say it. And finally, tell us what you've said..."

Conference on Alcoholism

The Governor's Conference on Alcoholism, on April 9 at Kam Auditorium, was well attended, especially by paramedical people. Bill Sage read his lecture on problems in diagnosis, especially when there are multiple injuries involved. We gathered from Col. Clothilde Bowen's lecture on the criteria for hospitalization that practically all alcoholics should be confined. Ray Tamura gave us practical information on drugs and dosages. Ray feels that physical restraints are no longer necessary because chemical restraints are available. He prefers Librium 100 mg IM on admission and 25 mg per os qid. His second choice is paraldehyde 10 cc per os every 6 hrs. (which Col. Bowen abhors), and his third choice is Mellaril 100 mg bid for 2 days and 50 mg bid until intake improves. Parenteral fluids are to be avoided since alcoholics are usually well hydrated. Clothilde prefers that alcoholics be kept in a lighted room and in some-

continued page 556



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one's presence. She uses Dilantin routinely in acute alcoholism to prevent seizures.

Concert Hi-Lites

On Barati night, we could see **Hunky Chun**, tall and debonair, in the left rear row of the Honolulu Chorale group howling away with the pack. During the intermission, we turned around and found **Noboru Oishi**, his head buried in the stock market page of the evening paper, peering carefully at the figures in the dim light. **Nobu Nakasone**, long an anti-Barati force, revealed his basic sentiments by marching abruptly out of the concert hall before Barati had finished his curtain calls. Then on La Marchina night, Nobu was the first to rise for the standing ovation. Of course, honesty is the best policy, but... In the front row of nearly every concert, we could see music lover **Kiku Kuramoto** slumped in his seat with his nodding head keeping time with the music, even when the music had stopped... To each his own...

Embarrassing Moments

The tense, neurotic young woman was seen several times for a bizarre debilitating headache which did not fit any pattern and failed to respond to medication. When all screening tests and x-rays were normal, we carefully explained that this was probably a tension headache. On her sick leave slip under "Remarks" we hastily abbreviated "Tension HA?" A few days later, she stormed into the office and immediately launched into a tirade, the distilled essence of which seemed to indicate that we were sarcastic, insolent SOB's. We were too perplexed, hurt, and angry to realize until she had stormed out that she must have thought we had written "Tension ha!"

Our teenage son had an appointment to see ENT man **Hideo Oshiro** for his chronic nasal allergy. With typical

teenage flippancy, he forgot the doctor's first name and looked on the Medical Arts Bldg. directory where he found OB-Gyn man **Tom Oshiro's** name and room number. As he was tripping merrily along to Tom's office, fortunately he met an adult acquaintance who inquired where he was going. Larry gaily responded, "Oh, I'm going to see Dr. Thomas Oshiro for a check-up."

The Kuakini Executive Committee was in session. It was time to automatically approve the same outdated consulting medical staff and honorary staff for the umpteenth time. **Masaru Koike** complained, "Every year I ask the same question, 'Why do we need a consulting medical staff and honorary staff?' and every year I get the same answer that it is in the bylaws." **Yosh Yoshida**, whom we strongly suspect to be an anarchist, chipped in, "If the only reason is that it is in the bylaws, then let's eliminate the bylaws."

Sportsmen

Turf Diggers: The annual HMA golf tournament was held on May 23 at the difficult par 71 Mauna Kea course with those fast-breaking greens. As we had predicted, **Don Maruyama** fired a low gross 81 with net 71 to win both divisions. **Mike Okihiro** (who should have done better) was runner up in gross honors with an 86, and in third place were **Ike Nadamoto** and **Sam Haraguchi** with 87's. In the low net division, **Dick Omura** trailed Don by 2 strokes at 73. For 3rd place, there was a four-way tie. Wily **Bill Dang** shot a 102-27-75, **Ralph Cloward** shot 90-15-75, and both **Ike Nadamoto** and **Sam Haraguchi** had 87-12-75.

No wonder **Al Shimamura** looks so smugly happy these days. He scored a hole-in-one on the 173-yard No. 2 hole at WCC with a 4 iron on May 29. **Ike Nadamoto** was in his foursome.

Quiet **Frank Fukunaga** is a religious golfer. Whenever he muffs a shot, over the awesome stillness comes muffled, yet distinct, a strange Chinese incantation, "Ah Shit!... Ah Shit!" Frank will not elaborate, but we feel

continued page 558

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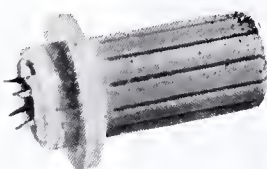
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Notes and News continued from 556

that the chant originates in some ancient Chinese religion and we are ready disciples since there is obvious improvement in his game after his chants.

In May, **Toots Fujii** won A flight stableford at WCC. **Allen Leong** tied for A flight and Allen and **Al Ho** won team tourney. **Buster Richardson** (turtle neck shirt and all) won B flight and Buster and **Richard Chun** tied for team tourney with two other teams.

In June, **Al "Bozo" Chun** led B flight in the best 16 of 18 tourney at Mid-Pac and also won in team tourney. Also at Mid-Pac, **Bill Dang** won B flight in the best 16 of 18 tourney. At WCC, **Al Ho** tied for A flight honors with a net 68 and **Richard Chun** won B flight.

Racketeers: Thirty-four stalwart men competed in the annual HMA Tennis Tournament held on a hot, humid Sunday, May 18. There were too many applicants in the Open (or beat the Yoshida-Fernandez team) Flight and the poor harassed tournament chairman had to plead with some of these contestants to enter the Closed (or pull-for-a-partner-on-the-day-of-the-tournament) Flight. As it turned out, they all had their partners chosen before the tournament. The Closed Tournament started at 8:00 A.M. at Iolani Courts and the matches were gruelling and prolonged. Finally through sheer talent and will power, the team of **George Suzuki-Simon Cheng** won the first place Geigy Trophy. **Larry Gordon** and **Bruce Joseph** showed skill and spunk to win the 2d place Path Lab Trophy. There were two teams, **Niall Scully-Bill Goebert** and **Howard Liljestrand-Walter Patterson**, tied at 3d. **Niall** and **Bill** later bested **Howard** and **Walter** in a playoff and won the 3d place A. H. Robins Trophy. In 5th place were the team of **John Balfour** and **Virge Jobe**, in 6th place, **Ted Tseu** and **Fred Dodge**; in 7th, **Jordan Popper** and **Young Paik**; and finally in 8th, **Mort Berk** and **Fred Gilbert**.

The Open Tournament was held in the afternoon at Beretania Tennis Courts. The traditional winning duo of **Yutaka Yoshida** and **Leabert Fernandez** (whose combined ages total 116 years) looked better than ever. **St. Francis** intern **Jon Betwee** and **Lance Richards**, Queen's resident and an A Class player, had youth and talent on their side, but then these young chaps graciously gave in to the oldsters' steadiness and tennis savvy. In 3d place were **Duke Choy** and **Walton Shim**, in 4th **Cal Sia** and **Hunky Chun**, and in 5th, **H. Yokoyama** and **Ben Tom** (these teams had a one-game point difference a piece). In 6th place were **Charley Ching** and **Larry Wong**, while Kaiser aspirants **Bal Raj Mehta** and **Alex Roth** came in 7th and **Jim Bennett** and **Vic Dizon** were in 8th. Last place was won by **George Kimata** and **Hiro Tottori**. First, second, or last place, we all had fun, exercise, and enough sun to last a long time.

Fishermen: The HMA Fishing Tournament was held on Sunday, May 18, with **Andy Morgan** as chairman. The prize for most fish caught went to **Harold Sexton's** "Alokai" with a total of 20 fish. Andy's "La-Iana" was close behind with 15. **Phil Jones** caught the largest mahimahi, weighing 22 pounds, and **Garton Wall** was second with a 20-pounder. Other winners included **Herb Uemura** with a 10-lb. aku, Andy with a 12-lb. kawakawa and **Tom Frissell** with a 5-lb. ahi.

In a Maui fishing tourney, **Frank St. Sure** caught a 34-lb. mahimahi to place among the winners.

Master fisherman **Diek Sakimoto** informs us that **Luke Tajima** was trolling on their "Kamome" with a 6-0 reel and using a 50-lb. test line when a kawakawa struck the lure. As Luke was reeling the kawakawa in, a 100-lb. marlin hit the kawakawa so Luke spent the next half hour bringing the marlin in.

Yachting: In May, **Jack Watson** was 2d in the Cal 20 class in the La Marina Sailing Club's Diamond Head race. **Les Vaseconcellos** was 4th in the 210's in the Wai-kiki Yacht Club's Jib Tender Regatta, off Diamond Head. Les was also entered in the 210 class annual Dillingham Koko Head race, in June. In an around-Oahu race, **Mel Levin's** "Calypso" (a 27-ft. fiberglass racer) was the big winner. The "Calypso" won in Class B and also took

over-all fleet honors. The crew consisted of **Mel Levin, Elmars Bitte, Alan Pavel, and Gerhard Frohlich**. The Levin-Bitte combo is proving that yachting partnership pays off. In the "big boat" class A title, **Fred Shepard** in the "Arjuna" won one race and placed 3d in another. He lost out in the coin flip when he was tied with another Fred, but gave notice that "It is more fun winning and I plan to make it a habit."

Other Sportsmen: **Boy Noyes** is a hiking enthusiast. He is the Sierra Club's outing committee chairman. **Ed Linn**, the boxing commission physician, frequently has to have police escort from the arena site when he calls off a fight and the decision is against a favorite son... Poor guy. **Richard You** is now supervising the conditioning of weight lifter Pat Omori who recently placed 2d in the 123½-lb. division at the National AAU championships. Richard is also working on Islander pitcher Bo Belinsky, and predicts that "there will be a new Belinsky."

Confrontation With Labor (July 1)

Some of the utterances by the labor panel consisting of Stephen Murin of the UPW, Christopher Hong of the HGEA, A. V. Dela Rosa of the Hotel Workers Union, Local 5, and Ah Quon McElrath, ILWU social and medical director, made our jaws drop with sheer wonder at the bristling hostility and pathetic ignorance expressed. Murin said in so many words, "In the eyes of our union members, the doctor today is income-conscious first and patient-conscious next... It's time you start worrying about your image... We want a voice in the planning of health care... We want to become involved in such matters as your income... We want a voice in setting up of rates... Your profession contradicts every rule of the free enterprise system, i.e., you have increased production, but your unit cost has gone up instead of down..."

Someone from the audience later asked, "Why should you have a voice in medical planning when we don't have a voice in the unions?" Stephen hedged an answer... Christopher Hong assailed the "anachronistic, unrealistic attitude" of the physicians. He condemned the duplication of facilities such as open heart surgery facilities at both Queen's and St. Francis Hospitals, and the pediatric wards at Queen's and St. Francis when there was a Children's Hospital. He said, "We must have a common report... We want to sit down to discuss these things... We want to clear up the mysteries we have about you..." Ah Quon McElrath said "It's time the medical profession came up with innovative programs to meet today's challenges... The doctors have failed to meet the challenges of the technical age... We should have greater utilization of paramedical personnel..." We lost A. V. Dela Rosa in a lot of mumbo jumbo of high sounding phrases and failed to understand what he said, but the hostility was evident in his tone, his eyes, and his mannerism and it was undeniably directed at us. We also grasped the intent of Ah Quon's words, "You must avoid the kind of confrontation which can be devastation..."

Our initial reaction was that of disbelief, then of dismay, and finally of anger. **Herb Wong** pleaded, "I have an adding machine which cost \$4,000. Please let me keep my adding machine." **Ray deHay** explained at length that overhead was lower when he was in solo practice than now that he is with a group. We could hear **John Keenan's** angry voice and watched with fascination as **Rowlin Lichter** nodded his head in approbation... A real verbal clash with the labor leaders was averted only by the objectivity of our firm moderator, **Cesar DeJesus**. When we had simmered down with the post-meeting beer and pretzels, it occurred to us that perhaps the blame is really with us, for we do not attempt to communicate with the consumer, as Labor has so aptly pointed out. But still we'll be damned if after letting insurance companies dictate our fees all these years, we will now let labor tell us what we should charge... ■

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Precautions: There have been infrequent reports of leukopenia and/or agranulocytosis and convulsive seizures. In epileptic patients, anticonvulsant medication should also be maintained. Pigmentary retinopathy may be avoided by remaining within the recommended limits of dosage. Administer cautiously to patients participating in activities requiring complete mental alertness (e.g., driving). Orthostatic hypotension is more common in females than in males. Do not use epinephrine in treating drug-induced hypotension. Daily doses in excess of 300 mg. should be used only in severe neuropsychiatric conditions.

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